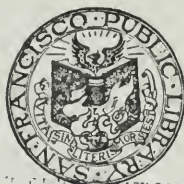




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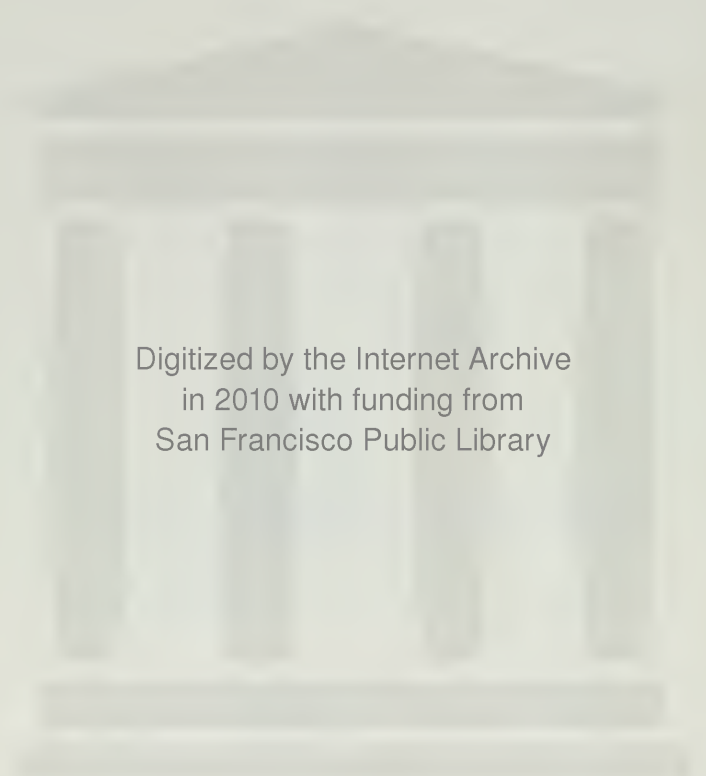
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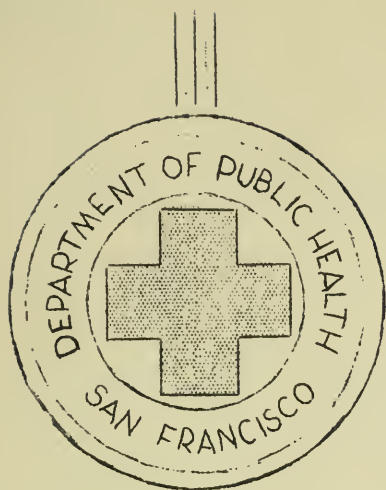
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SAN FRANCISCO

ANNUAL  
REPORT

1958-1959







# CITY AND COUNTY OF SAN FRANCISCO

## DEPARTMENT OF PUBLIC HEALTH

CENTRAL OFFICE

GROVE STREET (ZONE 2)

September 11, 1959

Through Mr. Sherman P. Duckel  
Chief Administrative Officer

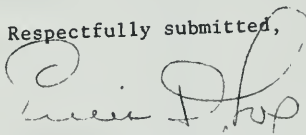
The Honorable George Christopher  
Mayor, City and County of San Francisco  
City Hall

Dear Mayor Christopher:

Transmitted herewith is the Annual Report of the Department of Public Health for the fiscal year 1958-59. The statistical information relating to births, deaths, and the incidence of disease is for the calendar year 1958.

This report presents to you a recapitulation of elements of progress and of some still unmet problems with which this department is involved.

Respectfully submitted,

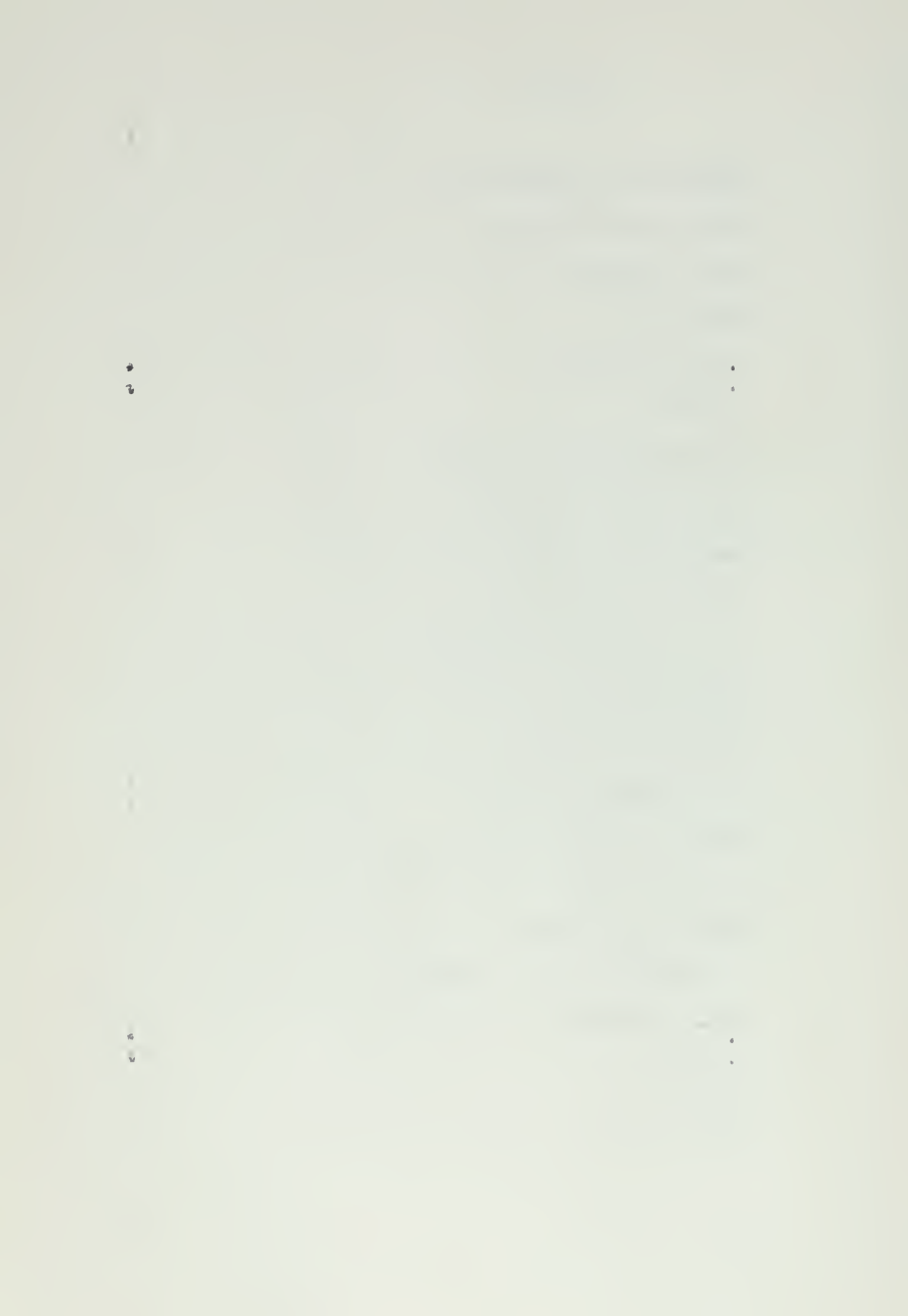


ELLIS D. SOX, M. D.  
Director of Public Health



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## SUMMARY AND RECOMMENDATIONS

### I. GENERAL RECOMMENDATIONS

In the interests of securing and retaining qualified professional and technical personnel, we recommend that:

- a. The appointing authority be given the option of selecting any of the top three on any Civil Service list and thus bring our Civil Service practices more in line with those of other jurisdictions. This discretionary power, we believe, would decrease the number of terminations during the probationary period, which is essentially costly in terms of orientation and training of new personnel.
- b. When the Board of Supervisors waives residence, such waiver shall include the consolidation of all candidates on one list so that all persons qualifying by examination shall be listed in order of grade points rather than the usual method of establishing two lists with those who are residents taking precedence over the non-residents. There has been great difficulty in securing outside candidates for professional and administrative positions because they are informed that any resident takes precedence over non-residents, irrespective of their actual grade points.
- c. The Civil Service Commission continue to give increased weight to the oral examination, particularly for administrative and supervisory positions, where an evaluation of the candidate and his past experience by an Oral Appraisal Board can be utilized to select persons that are qualified for such administrative or supervisory responsibility.

### II. THE STATE OF HEALTH OF THE PEOPLE OF SAN FRANCISCO

The data relating to births, deaths, and the incidence of disease are for the calendar year 1958 and are based on an estimated population of 791,000 as of July 1, 1958.

The crude death rate (deaths per 100,000 population) was 11.8 in 1958 as compared with 12.4 in 1957 and 12.0 in 1956. This decrease is significant when we consider that the estimated population upon which the figure is based was greater for 1958 than it was for 1957. Our death rate, however, is still considerably higher than that of the rest of the United States or of California, and is almost 80% higher than it is in Contra Costa, Marin, or San Mateo counties. These data and our considerably lower birth rate as compared with the surrounding counties is in part a reflection of the older population which San Francisco has.

The birth rate in San Francisco for 1958 was 19.1 as compared with 19.6 in 1957 and 18.2 in 1956. This rate is lower than those of our neighboring counties, and again reflects our smaller proportion of younger people.

The death rates due to specific diseases show us that the first six causes of death were slightly lower in 1958 than in 1957, with no change in their rank order. Deaths due to diseases of early infancy show a slight increase, and were greater than in any year of the last five, which is in part a reflection



of the higher birth rate among the non-white population, with a relatively high ratio of deaths during the first month, mostly related to premature births.

The death rate for tuberculosis was 9.7 per 100,000 population. This is the first time that the death rate has been below 10 in the history of San Francisco.

In the age group from 1 to 24, accidents are the Number One cause of death. From 1 through 14, malignancy is the second ranking cause of death. From 15 through 24, heart disease is the second ranking cause of death, with malignancy and suicide tied for third place. In the age group 25-44, accidents are the first cause, malignancy and heart disease tied for second, with suicides as the fourth cause. Cirrhosis of the liver was the fifth ranking cause in the age group 25-44. Cirrhosis of the liver is the third ranking cause in the age group 45-64, being exceeded by heart disease and malignancy. Accidents are the fifth ranking cause for the age group 45-64, and for those over 65. Of the 492 persons who died of accidents in 1958, 165 died as a result of falls; 108 of these were in the group over 65 years. The second cause of deaths from accidents was motor vehicle accidents, which resulted in 162 deaths. 37 of these were over 65, and 104 of these were between the ages of 20 and 64. 13 were less than 9 years of age.

A concerted effort on the part of the Police Department, the school system, and the Department of Public Health will continue to reduce traffic accidents. The extremely old and extremely young constitute the groups most difficult to educate. Although numerically the number of accidents occurring in the age group 20-64 is greater, the rate of accidents in the age group over 65 is almost  $2\frac{1}{2}$  times the rate of accidents in the age group 20-64.

The reports of communicable disease incidence reveal that gonorrheal infections were reported in greater numbers than ever before, with a rate of more than 300 per 100,000 population. Only measles had a greater incidence than gonorrheal infections.

Reported cases of tuberculosis continued to drop, being almost 9% lower than for 1957. It is interesting to note that the case rate for tuberculosis for the city as a whole was 62.4 per hundred thousand population. For the white race it was 45.9, for Negroes 166.7, for Chinese 143.8, for Japanese 120.0, and for all other races 369.0. By residential area, the highest rates were in the Central Health District, which includes most of the downtown area, with the Westside Health District, which includes the Fillmore District, being second highest. The third highest rate was in the Northeast district, which includes Chinatown and the North Beach area. The incidence of communicable diseases among the non-white population continues to be a major public health problem, and one against which we are focusing all of our available resources. Venereal diseases of all types show a total rate for San Francisco of 344.6 per 100,000 of total population, with an estimated rate of 212.9 for the white population, 2173.9 for the Negro population, and 127.3 for all other racial groups.

### III. GENERAL SANITATION SERVICES

The sanitation program of the Department touches the life of every individual in San Francisco, either directly or indirectly. During the past year, we have completed the generalization of our sanitation services so that at the present time there are 48 districts, each served by one sanitarian who has the responsibility for all sanitation services, including enforcement, within his district. This includes activities in the fields of food sanitation, general sanitation, the hygiene of housing, and the control of animals which may transmit diseases to the human population.





This consolidation will result in a more effective use of our personnel and will likewise decrease the number of persons who would otherwise be entering the same premises at different times for different reasons.

Emphasis continues to be increasing in the field of the hygiene of housing. This basic public health responsibility is carried out under the new Housing Code which was adopted a year ago. Our work is being integrated with that of the other code enforcement departments as a part of the Urban Renewal program upon which the City has embarked.

One of the major problems which confronts us is the number of families and single persons who are being displaced as a result of these joint activities in this field. The Department of Public Health is responsible for considerable displacement of persons whether or not there is any reconstruction being carried on. As this report points out, the returning of a building to its legally authorized use often decreases its capacity by as much as fifty per cent.

The housing from which these people are displaced is illegal housing and is sub-standard with fairly low rent. The problem such persons face is to find housing which is legal and which is safe, sanitary, and decent at a price they can afford to pay. This presents a basic problem for the City to face in its Urban Renewal program. We believe that ultimately some kind of financial offset will have to be provided to persons who cannot afford the present cost of legal housing. Whether this financial offset is by the construction of public housing, by the provision of an individual subsidy to the person paying the rent, or by the indirect subsidization of the contractor or the owner by providing him with a tax offset for a number of years or by any other feasible methods is one that will have to be determined in the near future.

Obviously, we cannot demolish existing structures and build new ones or rehabilitate existing structures without the resulting increase in rents. We must keep in mind the fact that we are providing housing for people and that we have a considerable proportion of our population, some of whom are single and some of whom are in families of considerable size, who have only a limited amount of money for the provision of housing.

#### IV. MATERNAL AND CHILD HEALTH SERVICES

Although there are continuing increases in the amount of problems with which this department must contend in the field of maternal and child health, we wish to point out that there has been only a minimum increase in the number of public health nursing personnel in the last ten years, and no increase in the number of medical personnel utilized in the provision of maternal and child health services. Although our total birth rate is not high, the birth rate among the non-white population, which happens to also be for the most part among those in the lower economic groups, is very high. It is these families, with their basic problems in growth and development and the prevention of disease and disability, toward which most of our maternal and child health services are directed.

Furthermore, with the continued increase in school population and an increase in the number of schools, both public and parochial, the spreading of our present personnel makes the depth of our services increasingly thinner.

#### V. PROVISION OF PREVENTIVE HEALTH SERVICES

During the many years this department has been in operation, it has operated through a number of health centers located throughout the City. The number of



these health centers for some years has been ten. The present number is nine, as a result of consolidation of the South of Market Health Center at 33 Hunt Street with the Central Health Center at 101 Grove Street. Through these health centers are provided the medical and nursing services necessary for the prevention of disease and the promotion of health.

During the past year, progress has been made in converting these health centers under the direction of the supervising public health nurse, to health centers under medical supervision, so that effective September 1 of this year each health center will be under the general clinical and administrative supervision of a district medical officer. All personnel assigned to these health centers are under the administrative supervision of this medical officer.

Every one of our health centers is overcrowded. Some of them are in need of complete replacement, and the request is before the State Department of Public Health for allocation of State and Federal funds to assist in the construction of one health center during the next fiscal year.

As new health centers are developed, we expect to assign also sanitation personnel, so that ultimately all of our general public health services will be provided on a neighborhood basis with emphasis varying with the basic problems in each of those particular neighborhoods.

#### VI. INSTITUTIONAL SERVICES

The medical care responsibilities of the department of course utilize the greatest portion of our budget. The Emergency Hospital Services continue to show an increase in persons served, and this service constitutes one of the most valuable services this department provides in the preservation of life and health.

The medical care institutions are of necessity under continuous change as the medical care problems change. The construction program at Laguna Honda Home is progressing at a rate where we anticipate that in January, 1960, 270 additional beds for care of long-term illness will be available. At this time, we propose to open 77 such beds on January 1, 1960 and an additional 77 on March 1, 1960.

If, however, the present rate of occupancy of San Francisco General Hospital continues to rise, we may find it necessary to open even a greater number of beds in each of these periods. By July 1, 1960 we estimate that all of these hospital beds will be occupied. There will then be a total of 1474 hospital beds at Laguna Honda Home as compared with the approximately 900 a year ago.

This will relieve some of the pressures faced by San Francisco General Hospital, which during the summer months has had an average occupancy considerably higher than in previous summer months. With the onset of winter weather, the San Francisco General Hospital will have a greatly increased occupancy in all probability in excess of 1050, and with the current construction program, which will continue for at least three years, that institution will have a rated occupancy of not more than 1000 beds. It will be probable, therefore, that the overcrowding of the wards may well continue.

Within the next months, we anticipate opening up at least forty additional beds for the chronically ill at Hassler Health Home, but we wish to point out that there is one major bottleneck in relieving the pressure of inpatient care. This is the fact that a great many of those persons receiving care both at San Francisco General Hospital and Laguna Honda Home have no homes to which they



can be released, even though they would not require hospital care if there were relatives with housing available. The great number of persons who are widowed and divorced and who live alone and the great number of persons who have responsible relatives without room for caring for elderly parents are the major reasons for the high occupancy of both San Francisco General Hospital and Laguna Honda Home.

## VII: APPRECIATION

What successes this department may have had during the past year are a reflection on the fine personal services provided by the more than 2800 employees of the department. Many of these personnel have worked far beyond their legal requirements, as far as their time and efforts are concerned.

Coupled with these paid employees is the work of many volunteers. The interest and activities of the Mental Health Advisory Board and the Health Advisory Board have been of great assistance in the administration of this department. The interest and assistance of the Chief Administrative Officer and of the staff of the Mayor's Office and of the Civil Service Commission and of other departments with which we are closely related is deeply appreciated.

The many thousands of man hours of the medical profession of San Francisco in our institutions has enabled us to maintain a high quality of medical services, and last but not least, the thousands of hours that lay people who work with volunteers in our institutions and in our preventive medical services have given have been most helpful. The services of these volunteer groups include not only hours of their own personal time, but in the cases of the volunteer organizations associated with San Francisco General Hospital and Laguna Honda Home, considerable amounts of money and of services that benefit both the patients and our employees have been forthcoming.

The change between an informal relationship and a formal relationship between the department and the University of California Medical School has been one of our greatest single elements of progress. The development of a contractual relationship between U.C. School of Medicine and this department for the supervision of medical care services at San Francisco General Hospital will, we feel, ultimately assist us in providing at San Francisco General Hospital a medical care program and a teaching program that will be outstanding in the United States. The close cooperation exhibited by various departments of City government and the faculty and administration of University of California School of Medicine made this transition possible.



## BUREAU OF RECORDS AND STATISTICS

### Birth and Death Registry

During the fiscal year 1958-59, fees collected for certified copies of birth and death certificates and burial permits amounted to \$66,488 an increase of \$649 or one percent over the \$65,839 collected during 1957-58. 20,302 births were registered, 22,966 certified copies of birth certificates were issued and \$21,373 in fees were collected, a decrease of \$2,366 or 10%. 9,998 deaths were registered, 37,023 certified copies of death certificates were issued and \$45,115 in fees were collected, a 7% increase. In addition, 197 fetal deaths were registered and 75 searches made.

Registration procedures are being reviewed by a joint State Health Department survey team and the staff of the Bureau in order to try to improve the quality of the certificates. It is hoped that some physical changes in the office setup can be made to improve working conditions, morale and efficiency.

### Vital Statistics

The population on July 1, 1958 as estimated by the California State Department of Finance was 791,100, an increase of 2% over the 1957 estimate of 776,000 and the 1950 census figure of 775,357. Estimated figures for racial groups are:

	<u>NUMBER</u>	<u>PERCENT</u>
<u>TOTAL</u>	<u>791,100</u>	<u>100.0</u>
White	688,000	87.0
Negro	55,200	7.0
Chinese	32,000	4.0
Japanese	7,500	0.9
Other	8,400	1.1

During 1958 there were 15,104 resident live births with a birth rate of 19.1 per 1,000 population compared to 15,240 births and a rate of 19.6 in 1957. The decrease was in part due to the decline in marriages in 1956 and 1957 and the 4% decrease in the number of first births and also to the increase in the estimated total population. However, both the United States and California birth rates dropped in 1958, perhaps for the same reasons, although rates for these jurisdictions as well as some nearby counties are, as usual, considerably higher than for San Francisco.

	<u>BIRTH RATES</u>		PER 1,000 Population	<u>DEATH RATES</u>	
	<u>1958</u>	<u>1957</u>		<u>1958</u>	<u>1957</u>
United States	24.3	25.0		9.5	9.6
California	23.7	25.5		8.5	8.7
San Francisco	19.1	19.6		11.8	12.4
Alameda County	23.0	23.9		9.2	9.5
Contra Costa Co.	24.0	25.5		6.5	6.4
Marin County	22.7	23.6		6.8	7.2
San Mateo County	23.1	25.1		6.5	5.8







The following table shows the pattern of births and deaths in San Francisco from 1950 on:

<u>YEAR</u>	<u>ESTIMATED POPULATION</u>	<u>RESIDENT BIRTHS</u>	<u>BIRTH RATE*</u>	<u>RESIDENT DEATHS</u>	<u>DEATH RATE*</u>
1950	775,357	15,477	20.0	9,204	11.9
1951	776,200	15,505	20.0	9,527	12.3
1952	791,500	15,710	19.8	9,693	12.2
1953	795,900	15,364	19.3	9,435	11.8
1954	798,300	15,171	19.0	9,160	11.5
1955	794,900	14,540	18.3	9,161	11.5
1956	798,900	14,565	18.2	9,548	12.0
1957	776,000	15,240	19.6	9,600	12.4
1958	791,100	15,104	19.1	9,375	11.8

\* Rate per 1,000 population

There were 9,375 resident deaths in 1958. The rate of 11.8 is lower than the two previous years but higher than the rate of 11.5 in 1954 and 1955. The age-adjusted death rate in 1958 was 9.0, almost 14% higher than the national age-adjusted death rate.

Crude death rates in San Francisco, California and the United States were all slightly lower in 1958 than in 1957; however, San Francisco's rate of 11.8 per 1,000 population was, as always, appreciably higher than the rate of 8.5 for the state and 9.5 for the nation. The decrease in respiratory infections since April, 1958 helped lower the overall death rate, the rates for influenza and pneumonia and to some extent, the rates for the cardiovascular renal diseases in the three areas. While in San Francisco the suicide rate remained the same, 25.0 per 100,000 population, the rate in the United States increased from 9.4 to 10.4 and in California from 14.6 to 16.4. However, suicides remained in 8th place in San Francisco, 9th place in California and 11th in the United States. Accidents decreased slightly but certain diseases of early infancy increased although the major causes of death showed the same relative standing on the lists as in 1957.

More cases of communicable diseases were reported in 1958 than any year since 1954. Most important is the increase in the venereal diseases, which is discussed elsewhere in this report. The fluctuations in occurrence of most of the childhood diseases were within the median range of these diseases for the past five years; the 1,530 cases of German measles, however, were considerably higher than any year since 1949 when 2,511 cases were reported. 1958 was the first year in San Francisco history without a case of diphtheria. The total of 70 cases of infectious hepatitis in 1958 was nearly twice as high as the 37 reported in 1957 but during the first six months of 1959, San Francisco has not been experiencing the increase in cases current in other parts of the country. Poliomyelitis experience was quite favorable; by date of onset there were 10 cases during the calendar year 1958; 6 were spinal-paralytic, 2 bulbo-spinal and 2 were non-paralytic. Although there have been "low" years in polio incidence prior to 1957 and 1958, part of the decrease may be attributed to vaccination. Half the reported cases did not receive any vaccine and it is strongly urged that those who have not yet been vaccinated do so.

Detailed information about San Francisco's vital statistics can be found in the Department's Statistical Report for 1958.



TABLE 1

DEATHS FROM IMPORTANT CAUSES  
SAN FRANCISCO, CALIFORNIA & UNITED STATES

CODED CAUSE OF DEATH	1958								
	RANK			RATE PER 100,000 ESTIMATED POPULATION			PERCENT OF TOTAL DEATHS		
	<u>S.F.</u>	<u>Cal.</u>	<u>U.S.</u>	<u>S.F.</u>	<u>Cal.</u>	<u>U.S.</u>	<u>S.F.</u>	<u>Cal.</u>	<u>U.S.</u>
TOTAL	-	-	-	1185.1	851.4	950.6	100.0	100.0	100.0
Heart Diseases	1	1	1	459.5	315.3	365.8	38.8	37.0	38.5
Malignant Neoplasms	2	2	2	203.8	138.7	146.2	17.2	16.3	15.4
Vascular Lesions	3	3	3	121.7	93.9	110.9	10.3	11.0	11.7
Accidents	4	4	4	62.2	50.4	52.6	5.2	5.9	5.5
Cirrhosis of Liver	5	8	10	45.9	16.5	10.6	3.9	1.9	1.1
Influenza & Pneumonia	6	6	6	36.2	27.9	33.1	3.1	3.3	3.5
Certain Diseases of Early Infancy	7	5	5	33.4	37.1	40.1	2.8	4.4	4.2
Suicides	8	9	11	25.0	16.4	10.4	2.1	1.9	1.1
Arteriosclerosis	9	7	7	21.5	20.2	20.0	1.8	2.4	2.1
Ulcers of Stomach & Duodenum	10	12	13	13.5	7.1	6.2	1.1	0.8	0.6
Diabetes	11	11	8	13.3	9.8	15.3	1.1	1.2	1.6
Tuberculosis	12	13	12	9.7	5.9	6.9	0.8	0.7	0.7
Congenital Malformations	13	10	9	9.1	12.0	12.0	0.8	1.4	1.3
ALL OTHER CAUSES	-	-	-	130.3	100.2	120.5	11.0	11.8	12.7

Sources: City and County of San Francisco Department of Public Health Records.  
 California: Communication from State Department of Public Health.  
 U.S.: Monthly Vital Statistics Report Volume 8, Number 1,  
 March 17, 1959.



## DIVISION OF PUBLIC HEALTH EDUCATION

The Division of Public Health Education participates in joint program planning within the Department and in our general community relationships. It assists the Department staff in the carrying out of Department programs by the proper use of all media of communication. It has the responsibility for the selection, preparation and distribution of various types of educational material. It helps maintain liaison with community organizations and the services of the Department by participation in conferences and meetings and on committees. It has the responsibility for the preparation of the Weekly Bulletin published by this Department and other responsibilities involving such things as in-service training for staff, orientation of new employees and the development of staff meetings and workshops.

Services from the health education staff are given to both staff and the public. Examples of these services include: (1) operation of a loan library of health films, (2) preparation of health exhibits, (3) procurement and distribution of health education pamphlets and posters, (4) service on community committees concerned with health, (5) maintenance and operation of audiovisual equipment and instruction of staff on its use, (6) advising on suitability of health education materials, (7) dissemination of information through radio, television and the press, (8) consultation to professional staff on educational methods, (9) answering letters and inquiries requesting health information.

Approximately 125 sound motion pictures and 50 film strips, both silent and sound, are available for loan from the Division for use in San Francisco. The operation of this Film Loan Library includes consultation on the selection and use of educational films, scheduling, inspection and repair of films and procurement of films from outside sources for use by the Department staff. Based on a tabulation of the film report forms the following table shows use of this service for the last three years:

<u>Fiscal Year</u>	<u>Number of Requests for Films</u>	<u>Number of Film Showings</u>	<u>Total in Attendance</u>
1956 - 1957	1,445	2,558	99,554
1957 - 1958	1,605	2,321	88,341
1958 - 1959	1,392	1,604	56,614

A supply of approximately 90,000 pamphlets, leaflets, booklets and posters covering over 100 health subjects is maintained for distribution direct to the public and indirectly through other professional personnel of the Department. This service includes the screening and evaluation of printed materials, procurement from both pay and free sources, maintenance of a stockroom and distribution. In addition, consultation and advice is given on the selection and effective use of these materials.

The following table shows the distribution of pamphlet material for the last three years:

<u>Fiscal Year</u>	<u>District Health Centers</u>	<u>Other Health Dept. Divisions</u>	<u>Directly to Public</u>	<u>Total</u>
1956 - 1957	65,236	16,460	16,631	98,327
1957 - 1958	74,189	11,037	7,345	92,571
1958 - 1959	108,909	15,586	9,382	133,877

In addition, health posters were distributed as follows: 1956-57 - 3,800, 1957-8 - 2,915, 1958-9 - 2,488.

A reference library service is provided by the Division in that public health reference material including articles, reprints, reports, pamphlets etc., is maintained for use by both the staff and the public.





## BACTERIOLOGICAL AND SEROLOGICAL LABORATORIES

Under California State law all Public Health Microbiological and Serological Laboratories must be licensed and all public health professional personnel must be certified. Certification requires passing a California State Department of Health Examination. Passing an examination from the State Department of Agriculture is mandatory if milk control work is done. The State Department of Public Health complies with standards set by the American Public Health Association and the Laboratories of the Public Health Service under the United States Department of Health, Education and Welfare. Keeping our license depends upon the fact that personnel and methodology meet recommended standards.

We provide two types of service (a) Sanitary Control and (b) Communicable Disease Diagnostic Service resulting in cooperation with most divisions of the Health Department. Specimens are received from Food and Sanitation, Dairy and Milk Inspection, Water Department, Communicable Disease including Tuberculosis and Venereal Disease, Cardiac Diagnostic Center, Public Health Nursing, Hassler Health Home, Laguna Honda Home and San Francisco General Hospital. Clinical work at the hospitals is provided by their own laboratories. Work done for the Police Department and for Youth Guidance Center necessitates appearing in court or before the Grand Jury. Services are extended to charitable agencies, clinics, and private physicians when the patient is indigent. We also provide consultation and reference service to physicians, private or hospital laboratories regarding methodology or help in solving laboratory problems. We also maintain professional relationship with the State Board of Health and allied scientific groups. Our laboratory has received a high rating in all evaluation studies conducted by the State Board. During the fiscal year 1958-1959 our Bacteriological and Serological Laboratory received 110,602 specimens compared to 106,940 specimens received during 1957-1958. This is an increase of 3,662 or 3.4%.

(a) **SANITARY CONTROL:** No changes are anticipated at the present time. Standard methods are used. 25,106 specimens or 22.7% of our work load were received from the Dairy and Milk Inspection Division while 2,390 Water Samples or 2.1% of work load were tested. Only 27 specimens of shellfish were received for examination. There has been a slight increase in the number (1,774 or 1.6% of work load) of cup and glass washings from restaurants and bars and in the samples of food (273) submitted for examination for micro-organisms causing food poisoning. During the past year we have had four outbreaks of food poisoning involving three restaurants and one bakery. Hemolytic coagulase positive staphylococcus aureus was isolated and the food handlers suspected of being responsible were identified. Changes were recommended by the Inspection Division to eliminate future trouble.

(b) **COMMUNICABLE DISEASE CONTROL:** The increased number of specimens received from the Venereal Disease Division of Communicable Disease Control reflects the rising incidence of primary syphilis and gonorrhea. 873 spinal fluids and 40,793 samples of blood, making a total of 41,666 specimens or 37% of our work load were received for serology during fiscal year 1958-59, against 1,089 spinal fluids and 40,204 blood specimens, a total of 41,293 specimens or 38.6% of total work load during 1957-1958. Changes made in the method of determining total protein in spinal fluids appears to have brought closer agreement with clinical findings.

Cell counts on spinal fluids, direct darkfield examinations for spirochetes and direct smears for gonococci have been deleted from our program and are done at the Health Department Clinic at 33 Hunt Street. Cultures for gonococci handled by our laboratory increased from 17,946 or 16.7% of work load in 1957-1958 to 21,698 or





19.6% of work load in 1958-1959. 99 Agglutination tests for typhoid H and O, paratyphoid B, brucella and tularemia were done in 1958-1959 against 48 in 1957-1958. Owing to the shortage of one or more staff microbiologists during the past year, antistreptolysin-O determinations have not been done for some time. This, as well as sedimentation rates, will be resumed for our heart clinic when we have a full crew. Shortage of personnel and funds for supplies and equipment precludes the inclusion of programs involving antibiotic resistant strains of staphylococci or the strains of hemolytic streptococci involved in rheumatic fever with its resultant heart damage in children. These are now looked upon as public health problems and should be considered for the future.

In tuberculosis control 14,118 specimens or 12.7% of work load were received in 1958-1959 and 13,627 specimens or 12.7% of work load in 1957-1958. This represents an increase of 491 specimens or 3.6% which parallels the overall work load increase. In spite of great advances in the treatment and cure of tuberculosis, the problem of its control and eradication still remains a major public health challenge. The greater use of antibiotics and chemotherapeutics in treatment with the development of resistant types of acid fast bacilli calls for more and better aid from the laboratory. Emphasis is shifting from x-ray to cultural methods for earlier diagnosis and evaluation of treatment. The day is passed when all the laboratory was called upon to do was to identify acid fast bacilli in a smear. Today there is an increased number of requests for cultures and sensitivity studies leading to increased costs of the materials needed and of microbiologists time and dovetailing of effort. This shifting of emphasis is shown in the following table:

	1957-1958	1958-1959
Direct Smears . . . . .	8,433	5,976 or minus 2,457
Smears on concentrated material . . . .	-	1,312 or plus 1,312
Cultures . . . . .	5,168	6,809 or plus 1,641
Sensitivity Tests . . . . .	130	143 or plus 13

Refinements of cultural methods to separate pathogenic acid fast bacilli from significant or non-pathogens are being developed and should be incorporated into future programming.

What the role of our Public Health Laboratory will be in V.D. Serology and T.B. programs is hard to evaluate because these are slated to become part of the overall laboratory setup at the San Francisco General Hospital. In our planning, we must see that the preventive laboratory services which protect the health of all San Franciscans is not overshadowed by the some times more acute laboratory needs of a hospital, which serves only a small segment of the population.

The handling of pathogenic enteric material for bacteriology or parasitology is another important function. Release cultures for all such cases within San Francisco should come under the jurisdiction of our Communicable Disease Bureau and be done at our laboratory. This service should be extended to include check specimens for other laboratories and physicians.

The only virus work done in our laboratory is examination for rabies. Brains of animals are submitted because of a history of abnormal behavior or of having bitten a person. Rabies is still a threat owing to the presence of rabid animals in surrounding counties.

Our greatest problems have been (1) shortage of personnel and (2) shortage of funds for supplies and equipment. All laboratories face these same conditions but others have modernized equipment, extended services and granted increased salaries.



Requests for expansion of services cannot be met under present budget allotments. Funds are not available for the payment of salaries commensurate with those paid in fields calling for similar educational background. This is limiting the number of people entering the public health field at a time when there is a demand for an increased number of certified microbiologists. In our laboratory experienced workers are not receiving salaries in keeping with the responsibilities placed upon them but are on the same pay scale as those just entering the field. Throughout the State the majority of laboratories employing three or more professional personnel have established supervisory positions directing microbiologists and responsible to the head of the laboratory. Twice, the Division of Laboratories of the California State Department of Public Health has investigated this laboratory and twice recommended that the organization provide two such positions. All such personnel would also be working microbiologists. A request for reclassification has been in the hands of the Civil Service Commission for almost eight months.



## CHEMICAL LABORATORIES

The function of the Chemical Laboratories is to perform chemical tests and analysis for the Inspection Divisions of the Department of Public Health, the Police Department, the California Highway Patrol, the Emergency Hospital Service, San Francisco General Hospital, San Francisco Water Department, School Department, Society for the Prevention of Cruelty to Animals, and other departments requesting these services to maintain the health and welfare of the people of San Francisco.

In addition to providing analytical services, the Chemical Laboratory also establishes proof in obtaining the conviction of suspected violators of the Health Regulations, and aids the official law enforcement agency in solving toxicological problems. A systematic check of foods, food products, milks, waters and air is indispensable in any organization responsible for safeguarding the community's health. For this reason the Health Department relies on the Chemical Laboratory to detect any infractions of the Health Code.

During the fiscal year 1958-59 the Chemical Laboratory received 7,184 samples and performed 20,545 tests, as compared to 6,750 samples and 20,536 tests for the fiscal year 1957-58; this was an increase of 434 samples or 6.4%. The number of tests performed were approximately the same for each year, but the man-hours per test were greater as shown by the total man-hours of 7,852 for the fiscal year 1958-59 as compared to 7,429 in 1957-58, an increase of 423 man hours, or 5.7%.

The adulteration of hamburgers and pork sausages by the addition of the preservative sulphite, "DYNAMITE" increased over 100% last year. Twenty-five (25) butchers were found guilty of adulterating their ground meat with sulphites this year as compared to twelve (12) last year. This is the greatest number of positives for preservatives found in the history of the laboratory. Sulphite is a prohibited chemical, commonly used for cleaning washrooms and butchers' equipment, which can retard and cover up the signs of decay in meat, giving the ground meat a bright red appearance. Another adulterant in ground meat more prevalent this past year than in previous years is the addition of too much fat. There were seventeen (17) samples of hamburger and pork sausages that had over the legal sample of 30% fat for hamburger and 50% fat for pork sausage.

The adulteration of processed meats, frankfurters, bologna, salami, etc. has increased almost 100% over other years. There were 241 samples of processed meats submitted to the laboratory for analysis; of these 73 had over the legal limit of 3.5% dry skim milk. Five had too much cereal (flour). Thirty-two samples had more than the 10% added water permitted in frankfurters, bologna, etc., and five samples had over the legal limit of fat.

The number of samples of stomach contents (gastric washings) this past fiscal year was 1170. The stomach contents are submitted by the Emergency Hospitals from cases involving poisons taken accidentally or with suicidal intent. Aspirin in one form or another continues to be the greatest offender, especially among children under 5 years of age. There were 221 positive indications for aspirin. Barbiturate ingestion was second with 219, the majority from adults taken with suicidal intent. The third main offender is arsenic, taken in the form of ant poison mainly by children under 3 years of age. Ant poisons



(Argentine Ant Syrup) is a sweet syrupy liquid containing a toxic amount of arsenic. The open bottle containing the syrup is placed around the house and yard to attract and kill ants. Children will eat this syrup, enticed by its sweetness. This is especially prevalent in the fall of the year when ants are the most numerous. There were 19 positive cases this year. When a positive for arsenic is found by the Chemical Laboratory, the patient's doctor is immediately notified in order that the physician may start treatment or watch for arsenic poisoning symptoms. Luckily, in most cases mothers rush the child to an Emergency Hospital where the stomach is washed before the arsenic is absorbed.

The number of toxicological specimens submitted to the Chemical Laboratory for analysis have increased over 200% in the past year from 64 to 204 samples. Contributing to this increase is the use now by the laboratory of the Ultra-violet Spectrophotometer, Model "DU", for the qualitative and quantitative analysis of micro quantities of drugs in the blood and other body fluids. This service assists the doctors in obtaining an early diagnosis on a patient admitted to the San Francisco General Hospital in a coma with no history of cause. Specific treatment can then be administered to the patient. Many doctors have appreciated the prompt and accurate service and are taking more advantage of it.

The number of blood samples for the determination of alcohol in sobriety cases submitted by the San Francisco Police Department and the California Highway Patrol continues to increase. This past fiscal year 696 samples were submitted as compared to 686 for the previous year.

There were a total of 208 miscellaneous samples submitted including fifty foods for chemical poisoning; thirty-five foods for insect and rodent infestation and other extraneous matter; dishes made and painted in Japan were analyzed for the toxic lead content in the paint. There were many other odd-and-end samples. Each sample must be examined and analyzed according to its individual complaint and composition. It may take days to determine what toxic chemical is present, the quantity of this chemical and whether the quantity is toxic under normal use.

Performing tests in the Chemical Laboratory for the fiscal year 1958-59 required 7,852 man-hours. The dispensing of drugs and sundries demanded 137 man-hours, while telephone calls, attending meetings, holding classes in toxicology and orientation, appearing in court and interviews with inspectors, salesmen, etc. called for 624 man-hours. This made a total of 8,613 man-hours. Such a schedule left little time for research on new methods and reading, therefore most reading had to be done after hours or at home.





## DIVISION OF FOOD AND SANITATION

Primary functions of the Division of Food and Sanitation are designed to prevent the development of insanitary and unsafe conditions in the daily environment of people whether in the home, commercial, industrial, social, educational or recreational fields. Optimum desirable health and safety standards are brought about and maintained by efficient enforcement of local, state and federal laws in conjunction with sound public health educational practices. Accordingly, routine activities of the Division include protection of the drinking water supply, both public and private, bottled waters, ice, swimming pools and bathing beaches. Due to the fact that San Francisco distributes water to interstate carriers, steamships, railroads and airlines, daily reports of bacteriological findings of our municipal supply must be given to the United States Public Health Service and the California State Department of Public Health. The Department of Public Health is charged with this responsibility. This is accomplished by our inspectors obtaining samples at several designated inlets and outlets within the city and by the Water Department on transmission lines within the system outside the city limits. Whenever bacteriological examination indicates even a slight degree of pollution at any points throughout the system, immediate investigation is made and the cause of pollution eliminated.

Air pollution control includes elimination of point-source pollution and research. The latter includes sampling and an analysis of the atmosphere daily to determine the degree of pollution by oxidant level and radiological contamination. Sampling stations are located at Third and Market Streets, Third and Fourth Streets, and at Lands End. Under the supervision of the United States Public Health Service, San Francisco is one of 28 cities throughout the country engaged in air pollution research for the purpose of determining the effects, if any, atmospheric pollutants may have as the cause or exacerbation of lung cancer. This is accomplished by constant impingement of atmosphere 24 hours per day by three units at 101 Grove Street. Specimens are forwarded to the Robert A. Taft Engineering Center, National Air Sampling Network, Cincinnati, Ohio. At the time of sampling all meteorological conditions are observed and carefully recorded.

Although sewage treatment and disposal is not a function of the Health Department, we are required by state law to examine waters of bathing beaches and water sports recreational areas to determine the degree of pollution from treatment plants and raw sewage. The state law establishes certain standards that must be met. In the event of pollution beyond the maximum standards for a continuous period, it is incumbent upon the Director of Public Health to prohibit swimming and water contact sports within the affected area.

Housing inspection is one of the major functions of the Division. The Department has been charged with the enforcement of the State Housing Act since its inception. Presently, however, we shall be responsible for enforcement of certain provisions of a newly enacted local housing code the supersedes the state law. This includes issuance of a Permit of Occupancy to 10,000 multiple dwelling units and annual inspection of same; also city-wide participation in Urban Renewal activities in conjunction with other municipal departments. In this connection we are charged with the responsibility of prevention of blight and deterioration of structures due to neglect, overcrowding, obsolescence, illegal conversion, improper use, occupancy, poor sanitation, improper lighting and ventilation. One of our projects which is planned for completion sometime in 1960, is a survey of the entire city. We have already surveyed 288 blocks in the Western Addition area and have been engaged in elimination of substandard conditions as follows.



This is a brief general summary of the interim results of the San Francisco Department of Public Health's Urban Renewal (code enforcement) Program in the Western Addition Area, particularly those blocks adjacent to Redevelopment Area A.

The problems stressed are relative to the nonconforming conversions of buildings to a use and occupancy greater than originally intended, and the difficulties of reconversion to conforming use, with the resulting displacement of families.

Explanations of fact and comments of judgment appear in this report after certain items.

Buildings Inspected (Estimated)	600
Buildings Requiring Maximum Treatment Notices	232

Six hundred (600) buildings were inspected, with 232 buildings requiring maximum treatment notices. These were substandard buildings with serious problems of occupancy, safety and sanitation. Certain of the 368 buildings not receiving notices had deficiencies but not of the same seriousness of those receiving notices.

Buildings where major changes in occupancy have been obtained (Legal Reconversion)	137
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Buildings where partial compliance with occupancy and/or repair requirements have been met, but with major repairs remaining	58
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Buildings placed in complete compliance with notices, or with only minor repairs remaining	72
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A study of the foregoing three items reveals that of a total of 232 owners of buildings receiving maximum requirement notices, a good percentage of these owners have made a sincere attempt to place their buildings in a safe, sanitary and standard condition.

It is also obvious that complete compliance with requirements has not been obtained in every case.

The major difficulty of these cooperative owners became clear after numerous interviews in the office and field. Repairs, legal conversions and even reconversions required major financial expenditures, and loans were necessary but difficult to obtain.

The following is a consensus of opinion of the field staff, based on conversations with owners as to the reasons loans were difficult to obtain.

First and second loans were already on the buildings, thus no further financing was available except over a short term.

First and second loans were based on an illegal occupancy income. A return to original occupancy (invariably an occupancy reduction) would reduce income to a level where there was insufficient return to pay existing loans.

Certain owners were eligible or able to obtain financing but not in sufficient amounts to effect a complete reconversion and repair. In this last category fall a large number of buildings where only partial compliance has been obtained.



Original number of living units in the 137 buildings that have had major changes in occupancy (legal reconversions)	
(Actual number of living units the buildings were designed to contain)	485

Number of living units found on inspection of the 137 buildings that have undergone major changes in occupancy (legal reconversion)	942
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On the basis of the foregoing two items, it is readily ascertained that the number of living units found in the 137 buildings was approximately double the number of living units legally permitted within these buildings. This statement should not be interpreted to mean that each structure had twice the legally permitted number of living units, but rather the total number of living units for all buildings had been approximately doubled.

Present number of living units in the 137 buildings that have undergone major occupancy changes (legal reconversion)	439
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Total elimination of living units as a result of Health Department action	503
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Total number of buildings of the 137 buildings that have undergone major occupancy changes that have been converted to a legal occupancy greater than the original intended use and occupancy	15
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A minimum of one-half of the owners interviewed indicated they had investigated the possibility of retaining approximately the same number of living units by a legal conversions, and concluded it was not feasible. Their reasons were generally as follows:

1. Unable to obtain financing.
2. Construction, electrical, plumbing and facility requirements in an increased use and occupancy were prohibitive in cost.
3. Investment could not be recovered in an area where rents were low.

Considering the small number of buildings with a legal increase in occupancy, apparently their conclusions were valid.

Increased number of living units in the 15 buildings legally converted to a greater use and occupancy:	
Present number of living units	61
Original number of living units	<u>27</u>
Increase in Living Units	34

This department, being aware of the low vacancy factor in the city and particularly aware of the difficulty of low income groups obtaining legal relocation housing, encouraged owners of substandard buildings to legally increase their occupancies over original use. Notwithstanding all of the time, energy and service offered by our field staff to help owners in this respect, the total gain in new legal



occupancies over original occupancies is 34 new living units in 15 buildings. This appears to be additional proof of the owners' contentions that financing was difficult to obtain and an indication that they were of the opinion that it was economically unsound to convert to a greater legal multiple occupancy.

Structures condemned and referred to City Attorney's Office for abatement	31
Buildings with minor compliance or no compliance (pending condemnation)	37

In concluding this report, several points should be made clear:

1. The figures given are accurate as to the results of our code enforcement activities.
2. The figure given as the original number of living units in buildings is accurate in a minimum of 95 per cent of the buildings' however, the balance of the buildings, the remaining 5 per cent, have been converted so as to make identification a matter of estimate only.
3. The comments relative to financing, legal conversions to increased occupancy and financial feasibility are opinions based on conversations with owners. Specific questions were not asked of each owner, nor was a random sample taken. However, the men in the field, because of their interest in these basic problems, did enter into the general conversations along these lines and the opinions expressed here are accepted by this field staff.

Other activities of housing inspectors include investigations of complaints of nuisances in dwellings, such as improper storage of garbage, insanitary interior conditions, rodent infestations, illegal maintenance of small animals, insanitary yards, odors, insect nuisances, and noise disturbances by barking dogs, operation of machinery or other illegal activities not permitted in dwellings.

The Division is also responsible for licensing and regulating the operation of private ambulance companies; annual inspection of laundries, cigar factories, mattress factories, theaters, pet shops and animal hospitals; supervision of fumigations by pest control operators; and the collection and disposal of refuse and swill. Refuse collection control includes adjustments of commercial and industrial rates, household overcharges, complaints of improper collection, noise in the early morning hours, licensing of scavengers and inspection of trucks.

Although the Department is not charged with the responsibility of housing inspection of single-family dwellings and flats, we are responsible for the sanitary condition of same. During the last year a total of 11,232 inspections of dwellings were necessary, all of which were due to complaints of citizens and the police and fire departments.

The activities of Market-Food Inspectors include supervision of construction and maintenance of all buildings wherein food products are manufactured, stored, sold or prepared for distribution, and the inspection of all vehicles engaged in the distribution of foodstuffs. Special emphasis is placed upon public eating establishments and meat-food-products plants, the inspector must visit the plant once in the morning when the raw ingredients are being mixed and again in the afternoon when he stamps all finished products. The stamp has a specific number assigned by the State Department of Agriculture and when not in use is kept in a metal safe to which only the inspector and District Supervisor have a key.







A special activity is the conducting of Food Handlers' Educational Programs for those engaged in various positions in public eating establishments.

Inspection of all perishable, canned, bottled, packaged and frozen foods as to fitness for human consumption is carried on routinely. This includes daily inspection of live poultry brought into the city, and follow-up inspection in poultry-slaughtering establishments; regular inspection of wholesale fish plants, as well as all fishing craft and receiving plants at Fisherman's Wharf; routine inspection of public eating establishments and other food-handling establishments, including observation of quality of foods. The latter requires obtaining specimens for laboratory examination, quarantining and condemnations.

From July 1, 1958 through June 30, 1959 the Division of Food and Sanitation made a total of 160,571 inspections. A total of 6,526 miscellaneous samples were submitted to the laboratory for examination. Fifty-one alleged cases of food poisoning were investigated. 24,559,045 pounds of meat food products were inspected and passed.

A new activity of this Division is mosquito control and abatement. Following is a report of the work of the Division during the last fiscal year.

Totalling 1092 complaints received during the 12 month period, the most numerous complaints reported occurred between July and December with 1024 complaints received by the Health Department. September had its peak when 398 complaints reported of mosquito annoyances in that month. Likewise, the monthly total number of specimen samples submitted to the Health Department for identification was greatest in September.

Four species of mosquitoes were identified. In descending order of their predominance, the species were:

1. *Culex pipiens*
2. *Culex stigmatosoma*
3. *Culiseta incidens*
4. *Culiseta maccrackenae*

*Culex pipiens* and *Culex stigmatosoma* were evidently the two species of mosquitoes which victimized the residents of San Francisco. Both species are characteristically vicious biters and they annoy especially at night. Since there are many ideal breeding places in San Francisco where these species are able to produce in large numbers, infestation over a wide area would eventually result within a short period of time. Catch basins, drain sumps, utility vaults, and heavily shaded structures containing stagnant pools of water were observed to be the principal breeding sources.

There was no evidence of Anopheline mosquitoes breeding in San Francisco.

No mosquitoes of the *Aedes* species were found during the survey. Particularly concerned was the possible infestation of San Francisco by the species *Aedes varipalpus*, a tree-hole breeding mosquito and *Aedes squamiger*, a salt marsh breeding mosquito.

Gnats or midges were observed to have been prolific in such areas as Lake Merced, Stow Lake, Pine Lake, and the lagoon at the Palace of Fine Arts. Among the varieties of non-biting gnats inhabiting these areas, the small darker species could easily be mistaken for mosquitoes. In fact, residents living close to the lake areas had reported that they had been annoyed by these "mosquitoes". Those



complainants who were actually bitten by mosquitoes whose breeding places were located near the dwellings would invariably blame the gnats breeding in the lake for the inflictions.

In recommending measures of control to augment the present method being applied, consideration must be taken into account so far as cost and manpower are concerned. The present control measures used would suffice if actual mosquito bite complaints received remain under one hundred per month beginning in August.

In the event that the total number of complaints go above one hundred, we will pursue the following:

1. BLOCK OUT AREAS WHERE MOSQUITO INFESTATIONS ARE HEAVIEST.  
The Survey Map will serve a helpful medium in determining the locations and extents of these areas.
2. SPRAY ALL CATCH BASINS WITHIN THESE AREAS AT LEAST ONCE A WEEK.  
Mosquitoes of the species *Culex pipiens* complete their aquatic life cycles from 8 to 15 days, depending on atmospheric and water temperatures. Oil film covering the water surface may break in less than half an hour. This occurrence will not impede the efficacy of the control measure because the larvae and pupae will have to surface themselves for air intake several times within a few minutes. With 10 percent DDT in oil solvent only a few repeated contacts with the emulsion would be sufficient to impregnate the air tubes and permeate the delicate skins of the larvae and pupae with lethal dosage of DDT. Therefore, the problem of catch basins occasionally being flushed with water from street cleaning sprinklers is negligible provided at least 10 to 15 minutes elapse between the insecticide spraying and street washing operations.
3. SPRAY PARTICULARLY THE WALL AND IRON GRATING COVER OF THE CATCH BASIN SO AS TO LEAVE DEPOSITS OF DDT RESIDUAL.  
In laying their eggs, averaging 200 eggs per mosquito for *Culex pipiens*, the mosquitoes will generally alight on a dry surface close to the water level. Adult *Culex pipiens*, when newly emerged from the pupal stage, will rest on dry surfaces for several hours before seeking for their meals--for blood meals in the case of female mosquitoes.
4. ENLIST THE AIDS OF THE SCHOOL AND PARK-RECREATION DEPARTMENTS AS WELL AS THE UTILITY COMPANIES TO SPRAY AT LEAST ONCE A WEEK ALL WATER RETAINING STRUCTURES LOCATED WITHIN THEIR JURISDICTIONS.  
Where large pools and ponds are involved, as those found in the Golden Gate Park, removal of weeds, grasses, and decaying organic matter from the water edges might deter mosquitoes from laying their eggs.
5. SYSTEMATICALLY SPRAY ALL BREEDING PLACES AND RECORD EACH LOCALITY SPRAYED EACH DAY TO DETERMINE SUBSEQUENT SPRAYINGS.
6. MAINTAIN THE PRESENT ASSIGNMENTS PERFORMED BY THE INSPECTION FORCES OF THE CITY DEPARTMENTS CONCERNED TO INVESTIGATE THE PREMISES OF DWELLINGS AND COMMERCIAL BUILDINGS FOR BREEDING SOURCES UPON RECEIVING MOSQUITO BITE COMPLAINTS.

#### SURVEY REPORT COVERS A 12-MONTH PERIOD

Although the mosquito survey is still in progress, this report encompasses a period of 12 months, from the inception of the survey in July of 1958 to the



end of June 1959. The amount of complaints received from July to December seem to indicate that heavy infestation occurred during these months. Substantiating this fact were the relatively large number of specimen samples submitted to the Health Department from August to October. September peaked in the monthly total number of complaints reported. Likewise, the monthly total number of specimen samples submitted was greater in September.

#### FOUR SPECIES OF MOSQUITOES IDENTIFIED

Identification of the specimens revealed the presence of four species in the mosquito population. These species were the following: Culex pipiens, Culex stigmatosoma, Culiseta incidens, and Culiseta maccrackenae.

##### Culex pipiens:

Mosquitoes of the species Culex pipiens predominated in the samples collected. Since the samples were obtained in various areas of San Francisco, it is positive indication that Culex pipiens were prevalent and in greater number of the total mosquito population. Because Culex pipiens breeds by preference in foul water, almost well covered or at least heavily shaded, and because the street catch basins, drain sumps, utility vaults, and certain neglected leaky plumbing fixtures creating stagnant pools in cellars of buildings, are ideal breeding situations, in close proximity to the human populace, one can expect that the mosquitoes would produce in great numbers and invade a large residential area within a short period of time. The unusual continual warm weather prevailed in the late summer and early fall of last year undoubtedly played a determining factor in hastening the aquatic life cycle. Being vicious biters, feeding mostly at night, female adults of the species Culex pipiens were evidently the cause for the numerous mosquito bite complaints.

##### Culex stigmatosoma:

Adding to the total mosquito population were mosquitoes of the species Culex stigmatosoma. Second in prevalence this species oftentimes commingled with that of Culex pipiens in the same breeding places. Its natural habitat, however, are the edges of pools where vegetations are found. Larvae and pupae were found in abundance at Golden Gate Park, along edges of ponds where freshly cut blades of grasses accumulated.

##### Culiseta incidens:

The adult mosquitoes of the species Culiseta incidens are much larger than those of the other two species mentioned above; but they are not vicious biters. They feed much more readily on blood of fowls and domestic animals. It is likely that when mosquitoes of this species are found in any building, to be found also are domestic animals. With a New Jersey light trap numerous adult mosquitoes of Culiseta incidens were captured near the animal cages in the Fleishhacker Zoo.

##### Culiseta maccrackenae:

The least number in prevalence during the 12 month period were the mosquitoes of the species Culiseta maccrackenae. In several occasions these mosquitoes were found breeding in fish ponds where leaves and other organic matter have settled to the bottom of stagnant water devoid of fishes.

#### NO POSITIVE EVIDENCE OF INFESTATION BY THE AEDES GROUP

It is unascertainable whether or not species of the genus Aedes infested San Francisco in the months prior to the inception of the survey in July of 1958. Specimens collected in light traps during the survey produced not a single adult





of the *Aedes* group. Especially watched for were the species *Aedes varipalpus*, a tree-hold breeding mosquito; and *Aedes squamiger*, a salt marsh breeding mosquito. These two varieties were reported to have been collected in San Francisco in the summer of 1956. Because rain water could be possibly collected in trunks of certain trees found in San Francisco, suspicion was first cast upon mosquitoes of the species *Aedes varipalpus* as the cause for the numerous mosquito bite complaints. However, the adult mosquitoes captured in heavily infested areas failed to show any sign of this species. Nevertheless, surveillance is still maintained for sudden increase in the mosquito population especially in the spring and early summer when the factors of rain and warm temperature will have been combined to hatch out the *Aedes varipalpus* eggs (if they do exist) which had been laid in the spring of the previous year, since this species usually has one brood a year.

The only time that San Francisco might experience a dense populace of the species *Aedes squamiger* is when a mass migration occurs, originating from neighboring counties where salt marshes are to be found. *Aedes squamiger* adults appear from approximately March to May and have a longevity of about 3 weeks. During this time the species has a tendency to disperse many miles. Under favorable wind conditions, this species could travel a range of 30 to 40 miles. Considering this fact, it is an almost futile task to be searching for breeding sources within its boundaries should San Francisco be heavily infested.

#### NO EVIDENCE OF THE PRESENCE OF ANOPHELES MOSQUITOES

Literature on mosquito distribution published by the California State Bureau of Vector Control mentioned of *Anopheles* mosquitoes collected in San Francisco in the previous years. Specimens submitted for identification during the survey failed to show, however, the presence of any *Anopheles* mosquito. It is to be noted, too, that the particular species of *Anopheles* which was found in San Francisco belongs to a costal variety of the sub-species *Anopheles maculipennis occidentalis* which is not normally a malaria vector. This subspecies is to be distinguished from another subspecies known as *Anopheles maculipennis freeborni*, commonly found in the interior region of California and considered to be an efficient vector of malaria.

#### GNAT OR MIDGE INFESTATION

One factor that perhaps aggravated the mosquito incidence problem and somewhat confused the general public was the accompanying heavy infestation of gnats or midges belonging to the family Chironomidae (now called Tedipedidae). Among the various types of gnats found breeding in such areas as Lake Merced, Stow Lake, Pine Lake, and the lagoon at the Palace of Fine Arts the small darker species could easily be mistaken for mosquitoes. Numerous adults of this particular type of species were discovered resting in the bushes along the banks of Lake Merced.

The gnats found in San Francisco do not bite. But on many occasions complainants had reported to the Health Department of these insects as "mosquito nuisances" regardless of whether or not the insects had bitten them. In instances where the complainants were actually bitten by mosquitoes, the blame would invariably be directed to the gnats breeding in the lakes as the culprits.

Although harmless, because of their characteristic behavior of forming in swarms, hovering close to a place of residence (oftentimes entering dwellings in large numbers), these gnats do create annoyance by their presence alone. In 1957 an





experiment was initiated to eliminate the gnat larvae in Clear Lake. One part of Rhothane insecticide (DDT or TBE) to 70 million parts of water resulted in a 100 percent larvae killed over the five-day period. However, complication began to manifest itself. Although the insecticide proved effective in killing the gnat larvae in the treated areas of Clear Lake, game fishes ingested the insecticide residual which was eventually deposited and accumulated in their fatty tissues. This summer an experiment will be conducted in Clear Lake by the California State Division of Environmental Sanitation using Parathion as larvicide. This compound in dosage lethal to insects is non-toxic to mammals and, unlike DDT, it will not leave a residual for fishes to ingest.



# DIVISION OF DAIRY AND MILK INSPECTION

The number and type of inspections made by personnel of the Dairy & Milk Inspection Division for periods between July 1, 1957 to and including June 30, 1959, also the estimated number of inspections that will be made for the fiscal year July 1, 1959 to June 30, 1960 are as follows:

<u>Functions</u>	<u>INSPECTIONS MADE</u>			
	<u>July 1, 1957</u> <u>June 30, 1958</u>	<u>July 1, 1958</u> <u>Dec. 31, 1958</u>	<u>Jan. 1, 1959</u> <u>June 30, 1959</u>	<u>Estimated</u> <u>July 1, 1959</u> <u>June 30, 1960</u>
Dairy Farms	14,928	7,354	7,377	14,500
Skimming & Cooling Stations	1,218	565	658	1,200
Pasteurizing Plants	1,282	663	586	1,300
Milk Wagons	206	134	71	250
Peddlers	1	0	2	5
Groceries, Delicatessens	1,893	1,170	1,009	2,000
Public Eating Places	31	42	34	80
Butter Factories	55	15	17	40
Cheese Factories	45	7	19	30
Ice Cream Factories	164	71	114	190
Miscellaneous	171	75	112	200
Complaints	25	14	21	40
Special Investigations	40	35	30	50
Conferences	137	65	105	150

The consumption of fluid market milk in this city for the calendar year 1958 amounted to 64,905 gallons per day, a decrease of 1,565 gallons from the previous year. Based on a population figure of 791,100, this represents a per capita consumption of .656 pints per person per day.

The breakdown of this gallonage is as follows:

Grade A pasteurized	64,905 gals., per day representing 99.94%	
	a decrease of	2.36%
Goat milk pasteurized	41 gals., per day representing .06%	
	an increase of	.07%
	64,946 gallons, a decrease of	2.35%

Included in the above are 4,672 gallons of milk pasteurized in adjacent counties and sold in San Francisco daily.

The consumption of half and half amounted to 3,751 gallons per day, or .0379 pints per capita, a decrease of .186% over the previous year.

An average of 742 gallons of cream was consumed daily, a decrease of 102 gallons per day, or 12.08% from the previous year. This amount of cream represents a per capita consumption of .0075 pints per day.

Miscellaneous products including 646 gallons of chocolate drink, 1,231 gallons buttermilk, approximately 168 gallons miscellaneous fermented drink, 2,065 gallons skim or nonfat milk, 485 gallons concentrated milk, 7 gallons strawberry drink and 1,371 gallons citrus drinks were consumed daily.



In addition to the 64,946 gallons of market milk pasteurized for sale daily in this city, 32,103 additional gallons were processed in our plants and sold for use overseas and in other counties.

Our market milk supply was produced on 743 dairy farms, 227 of these shipping directly to the eleven processing plants in the city, and 516 shipping through six skimming and cooling stations, under the supervision of this department, located in the country areas.

Dairy farms inspected by our department had an average score of 89.02%, the minimum being 70%.

Under the districting of dairy farm provisions of the Agricultural Code, our department supervised 218 dairy farms shipping milk into the jurisdiction of other milk inspection services, while other milk inspection services supervised 198 dairy farms shipping into plants under the jurisdiction of our inspection service.

During the year approximately 1,415 gallons of milk were condemned as unfit for human consumption on account of excessive sediment, and 19,420 gallons degraded to manufacturing purposes due to illegal temperatures.

Fifty milk product containers were condemned as unfit for use.

The decrease in consumption is thought to be due to alarmist statements appearing in the press, regarding the presence of strontium 90 in milk, and also statements attempting to link milk fat with heart disease.

The average quality of the several products, as determined chemically and bacteriologically, remains substantially as in the previous year.

When the Cryoscope, authorized in last year's budget, is installed and operating in the department laboratory, it is planned to follow up closely reports of low milk solids. This will result in a better control of adulteration.

It is also planned for the forthcoming year to continue and increase our pressure on dairy herd owners to reduce the amount of sediment in our milk supply, mainly by improved methods of preparing the animals for milking.



## BUREAU OF COMMUNICABLE DISEASES

The Bureau of Communicable Diseases, for purposes of administration, is divided into three major parts:

- a. The Division of Epidemiology
- b. The Division of Tuberculosis Control
- c. The Division of Venereal Disease Control

### EPIDEMIOLOGY

In those diseases in which specific preventive measures have been developed, the problem becomes one of individual personalized attack rather than the formula of mass approach found so useful in the past.

The continuance of the epidemiological and preventive approach is most needed if we are to maintain the excellent health record against these potentially dangerous and easily spread plagues.

The Bureau of Communicable Diseases has the responsibility of evaluating the communicable disease problems within the city and instituting measures toward prevention and control. This necessitates:

- a. Accurate diagnosis of cases.
- b. Epidemiological analysis of each problem.
- c. Institution of public health procedures often involving isolation and quarantine.
- d. Operation of free medical clinics for treatment.
- e. Supervision of cases and carriers as necessary.
- f. Because of the attendant disease possibilities this Bureau is also charged with the responsibility of enforcement of ordinances governing the operation of:
  1. Massage Parlor (Venereal disease foci)
  2. Tattoo Parlors (Transmission of diseases by inoculation)
  3. Pound (Transmission of rabies by animals)
- g. Advisory consultation is also offered hospitals, nurseries, Youth Guidance Center and other agencies concerning communicable diseases.

The program of the Bureau involves:

- a. Collection of morbidity statistics.
- b. Case finding with records and reports, diagnostic services and epidemiological study.
- c. Education in professional, patient and community fields.
- d. Coordination of all community activities and resources for handling communicable diseases. (Average 4,500 phone calls monthly).
- e. Issuance of travelers' certificates under United States Public Health Service regulations (involving 8,590 persons producing \$8,590.00 in fees for the past year).





The life expectancy of our generation is greater than that of any of our ancestors due to the application of known principles of preventive medicine. If the control of disease meant merely a prolonging of life without the extension of health, one might question its worth. The improvement in the general state of health and well-being of our population is difficult to measure statistically.

The effective control of many diseases has been the achievement of the Bureau of Communicable Diseases through the continuance of preventive measures. Our epidemiological attack has changed from the "mass approach" of previous years to one of "individualized personal study". This change has brought about a more concentrated epidemiological attack and in many instances has required much more personal interview time. As disease patterns change so too does the work of the Bureau of Communicable Diseases.

As a result of the various responsibilities assigned to our Bureau, every case reported, whether in the scope of specialized fields of tuberculosis and venereal diseases, or in the acute communicable disease groups, must be checked, investigated, studied and public health procedures initiated. A continuance of our preventive measures is most needed if we are to maintain our excellent health records against these potentially dangerous and easily spread diseases. Alertness is certainly a "by word" of our Division - diseases can and are spread so quickly and quietly.

In those diseases in which preventive measures are now available, the decline of incidence through the years has been most noticeable. Smallpox has been entirely eliminated from our community - our last epidemic occurred in 1946 when we had six cases. However, with the development of cases in other countries of the world and the extensive amount of travel of our citizens by air, we are ever aware and alert to the potential dangers of the introduction of this disease into our territory.

Diphtheria remains at a very low incidence with no cases being reported since 1957.

It is most gratifying to see that poliomyelitis, which was one of the most distressing problems to families, remains at a low ebb. Our high level of 288 cases reported in 1948 has dropped to 10 reported cases for 1958. To date for 1959 we have had 5 cases. Case histories reveal that all five cases were females - two in the age group of 2 - 3 years; two were 22 years of age and the other one was 51 years of age - all five had failed to take advantage of the Salk vaccine program. San Francisco joined the rest of the nation in 1955 and sponsored a mass vaccination program through June, 1958. It is most gratifying to note that the larger number of vaccinations were done in our 5 - 9 age group with the birth to four years of age following in a close second place. The discouraging point of the program was the lack of interest on the part of our young adults (age group 20 - 24 years) to take advantage of the program. As this age bracket is a high incidence group to this disease, much of our publicity was directed to these individuals. It is hoped that through education and personal contact our young adults will learn to protect themselves. Poliomyelitis vaccine is now offered in all Child Health Conferences throughout the city in the immunization program. We have been watching carefully and with great interest the clinical trials on the oral "live" vaccine. It is necessary to keep abreast of all new developments and to study the evaluation of the oral vaccine against the injection vaccine - time and experiments will give us our answer.

Recognized as an increasing problem with no achieved solution is the rise in the incidence of infectious hepatitis cases. An epidemiological investigation is made of each case reported. In one group of cases which appeared in one of the housing



projects, the common factor was personal contact. We have been unable to associate any of our cases with food or water supplies. Case reports increased from 37 in 1957 to 70 in 1958 with a total of 49 for the first 6 months of 1959 (not including serum hepatitis).

A continuing problem for our Division is the great increase in the shigellosis and salmonellosis cases. In 1957 we had 25 cases of shigella reported compared to 95 cases for the first 6 months of 1959. These cases require a great deal of follow-up work and investigation. No doubt these cases will continue to be a problem - considerable more time will have to be devoted to the control and investigation. Not only do we have the acute cases of these diseases but must constantly keep in mind and under surveillance the carriers. During the past few years more detailed work has been done by both the local and state laboratory in the identification of the causative organism. There is very close cooperation between the two departments and all reports on specimens received by the State Laboratory from all San Francisco hospitals are reported to our Division. This means we are "alert" to the development of cases and carriers within our jurisdiction. Many of these cases are kept under surveillance for many weeks and months, depending upon the individual's response to therapy.

Our typhoid fever cases remain low; however, we have had three cases reported for these early months of 1959. Our total cases reported for 1957 was one. It is indeed most gratifying to our staff when epidemiological work is completed on reported cases and the source of infection is found. We were able to discount one case when information was given of previous illness of patient during her stay in a foreign country. One case now under investigation has proven to be due to contact with known typhoid carriers. A constant duty of our Division is the supervision of approximately thirty-five known typhoid carriers within our jurisdiction. State law requires semi-annual rechecks on these people. A very excellent contact has been developed through the years with these carriers and our work with them has been most satisfactory. During the past year it has been our pleasure to release three of these carriers from the active list with the State Health Department. This procedure calls for very close cooperation with our Department from the patient. It is most interesting to note that all three of the above carriers first came to our attention in the 1940's. Many of our carriers have been known to us for twenty to thirty years and maintain a very friendly and satisfactory contact with us.

In connection with the United States Public Health Service we supervise and keep under surveillance eight Hansen's Disease cases. We are most fortunate in having as our consultant on these cases Dr. Paul Fasal, an outstanding authority on this disease. Reports are received routinely from Dr. Fasal and should questions arise on any of our cases, he is most cooperative and willing to assist us in any way we may request. Our staff must always keep in mind the possibility of these cases in our community due to the "constant flow" of the Orientals, Mexican and other races into our territory. Epidemiological studies on these cases most frequently reveal original infections to have occurred outside of the United States. In accordance with State requirements, family contacts must be examined annually over a period of time. These examinations are done by the Bureau of Communicable Diseases' physicians.

During the past two years our county has been surrounded by declared rabies areas. We have been most fortunate as we have not been involved but our general motto has been vigilance. To carry out this vigilance, all known animal bites are investigated and the animal placed on restricted activity for fourteen days. During the past year reports were received on approximately 1400 such bites. Animals involved are dogs, cats, rats, monkeys, hamsters, squirrels, horses, chipmunks and rabbits.



No bites have been reported involving bats or skunks (the main sources of infection in surrounding counties). A close working cooperation is maintained between our Department, the Police Department and the Society for the Prevention of Cruelty to Animals on control of animals for the fourteen day observation period following bites. Our laboratory has done many examinations on the brains of animals to rule out rabies. We are all ever alert to the possibility of rabies and every effort is made to keep this dreaded disease away from San Francisco. Our last case of human rabies was reported in 1940 - last animal rabies in 1941.

Of interest to and a warning sign to us was the reporting of two cases of bubonic plague within the last month in California. The last reports of this disease in San Francisco are recorded as five cases in 1908 - the record for 1907 was 154 cases. A little known but constant working program of our Department is the rat trapping and survey work. United States Public Health Service Plague Laboratory does the examinations. Staff assigned to this activity have been alerted to the recent development of cases.

With the outbreak of staphylococcus infections in the hospitals, our Division embarked upon a campaign of coordinated control with each hospital for programs to eradicate these infections. As a result, the hospitals created special committees, adopted new regulations and enforced a control program. Progress reports indicate already the effectiveness of these methods. The work is being continued and each medical staff member acts as a consultant to the hospital committee.

Encephalitis cases call for a constant vigil and an awareness of the problem. Due to the minute work on specimens now done at the State Laboratory, we have many more cases reported. Many of these cases fall into the category of measles and mumps encephalitis.

We have recently had an upswing in cases of staphylococcus food infection causing approximately fifty-three cases. A successful campaign was conducted and the suspected sources (two food handlers) were found. Through our system of examination of food handlers involved (nose and throat cultures and fingernail washings) we were able to find the specific line of transmission - thus we are able to stop the incidence in any one restaurant or food establishment. To date we have had reported 82 cases of food poisoning compared to 26 for the entire year of 1958. An infection in a popular eating place involves many people. Through excellent cooperation with our inspection division and laboratory staff, we are able to pinpoint many cases.

Many of our minor communicable disease cases have shown an increase during the first six months of 1959. A few figures follow showing comparison to the total number of these cases reported for 1958.

	<u>Jan. 1 - July 1, 1959</u>	<u>Year of 1958</u>
Chickenpox	1179	1282
Measles	1696	2490
Scarlet Fever	154	298

The enforcement of various ordinances is also the responsibility of the Bureau. Under the Massage Parlor Ordinance, each place of business and the operators are checked semi-annually and more often if conditions exist which need closer supervision. At the present time we have fifty under supervision. A close working cooperation is maintained with the Police Department on this supervision.





The certification of the United States Public Health Service travel certificates has greatly increased and must be integrated among the other work of our clerical staff. This service offers an opportunity for much public health education, as these citizens are informed concerning immunizations, vaccinations and general preventive procedures. These certifications were started in 1949 when 2387 were done. During 1958 the figure rose to 8590 and so far in 1959 the staff has certified 5002. The fees collected for this service meet a large part of the clerical payroll of the office.

The staff also contributes much time and effort in educating our citizens seeking information via as many as two hundred telephone calls daily. During a three month period 13,643 incoming calls were received. Many of these take considerable time and effort. No call received is ever allowed to be closed without directing the person to the correct facility for the desired information. Many times it means two or three calls to various agencies by our personnel to locate the proper information.

It is most gratifying to note that during the past year office consultations for the staff of epidemiologists has increased. Home visiting remains about the same in number, but due to the type of visits, when one considers our increase in shigellosis and such cases, the amount of time spent in home visiting has increased considerably. The investigation of these cases is time consuming in health education and communicable disease control for the family, the patient, the private doctor, the school and the general public.

The Bureau has been most fortunate in the personnel of the Epidemiology Division. The medical staff is an experienced staff in communicable disease control work as well as a staff which is informed of all late developments in the medical world and alert to world happenings in disease control.

The clerical staff is also an experienced group. We are most fortunate in the type of personnel we have had for many years. During the past six years we have had only one change in this group, when a very capable person left to accept a promotional job. It is due to the conscientious attitude of this group that our small staff has been able to accomplish the many detailed duties within our Division.

Both the medical and clerical staff is able when requested to expand and meet emergencies and to do an excellent job. At all times they must be alert to all new national and state regulations in communicable disease control.

It is most difficult to judge the excellent work done by the staff from just figures. One must be able to understand the detailed work demanded in the control of communicable diseases to thoroughly appreciate and realize the work done in this Division.

During the past year we lost our excellent Director through retirement. The Bureau had developed for the past thirty-six years under the careful supervision of Dr. George Becker. Although we now lack an Administrative Chief of the Division, we have enjoyed having Dr. Erwin C. Sage, Assistant Director of Public Health, as our Acting Director. He has been most helpful and considerate of our group. The staff is looking forward to the appointment of a new Administrative Chief and will give him their full cooperation and support as they did their past Chief.





## DIVISION OF TUBERCULOSIS CONTROL

Contrary to popular opinion tuberculosis remains a major public health problem. The gradual and continual decrease in the number of new cases reported annually has not been due to modern therapeutic methods. The trend was established during the early part of the twentieth century with the introduction of good public health practices, and has shown no marked deviation in recent years.

The anti-tuberculous drugs have eliminated many of the serious complications of tuberculosis which resulted in prolonged periods of hospitalization and a high death rate. This has brought about a complete change in the treatment program and the problems of Health Departments.

Prior to 1952, patients receiving maximum hospital benefit were institutionalized eighteen months for minimal disease, and from two to five years for advanced disease. The time required to render patients non-infectious or non-communicable, as judged by sputum conversion, was frequently one year or longer. The basic principles of treatment were bed rest, adequate diet, and good nursing care; frequently supplemented with some form of collapse therapy.

In 1952 and 1953 there was a long list of patients with active and communicable tuberculosis living at home, under observation at the Chest Clinic, who were waiting for a bed in the hospital. During 1952, there was an average daily census of 753 tuberculosis patients in San Francisco Hospital and Hassler Health Home. This was a record high; with a waiting list on the outside! Prior to 1956, the problem of hospital beds was so acute that the principal effort was focused upon the more cooperative patients.

Following the introduction of INH (an anti-tuberculous drug) in 1953, the entire picture changed. This drug, in conjunction with Streptomycin and PAS, when used in early disease, whether minimal or advanced, resulted in the prevention of many serious complications and death. Even in older advanced disease it was highly effective. In addition, 90% of the patients with new disease converted their sputum and became non-infectious after four months of therapy.

Patients did so well under the new regimen that prolonged hospitalization was not necessary for the majority. However, it has been established that most patients will require a minimum of two years of anti-microbial therapy, but usually only six to eight months of this time must be in an institution. Today, the average cooperative patient with new disease usually remains in the hospital for four to six months with minimal involvement and six to eight months with more extensive lesions. The remainder of treatment is given as an out-patient at the Chest Clinic. This has resulted in a marked increase in the actively treated patients in the clinic, and in increased PMN supervision in the home.

This change from prolonged to short-term hospitalization with completion of treatment at home and at the clinic has resulted in marked savings to the taxpayer. Patients can be effectively treated for approximately \$1.00 a day in the clinic, whereas it costs \$23.00 per day in the hospital. Since 1956, there has been no list of patients with tuberculosis waiting for admission to the hospital. The number of patients receiving active treatment in the clinic has increased from 5,771 or 23.5% of the total visits in 1952 to 26,441 or 83.5% of the total visits in 1958. A patient on active treatment receives a minimum of two, frequently three, and occasionally as many as seven clinic services per visit.



In order to care for the increased treatment load at the clinic it was necessary to evaluate all records in the active file and to close as many cases as possible. During this evaluation approximately 500 residents of neighboring counties were referred to the appropriate Health Department for follow-up. A large number of working patients who needed only an annual or semi-annual evaluation were referred to private physicians. The number of cases in the active files had been reduced from 18,400 in January, 1956 to 4,471 in December, 1958. During this same period the number of patient visits for active treatment increased from 19,975 to 26,441. This had resulted in the utilization of clinic personnel to the maximum consistent with good medical care as practiced in the community.

Whereas many benefits have been derived from the shorter periods of hospitalization, many new problems have arisen.

Patients treated outside the hospital must be followed closely and maintained on a strict medical program or they will reactivate their disease and become infectious. Popular opinions about anti-tuberculous drugs have made many patients, and physicians inexperienced in tuberculosis, complacent. Not infrequently, patients become careless about taking their medications only to reactivate their disease and infect close associates.

The uncooperative and recalcitrant patient cannot be kept in an institution legally once he is no longer infectious. This type of individual usually leaves the hospital against medical advice, fails to take his medication, very rapidly becomes communicable again, and spreads his disease in the community. This group is predominantly male, many are alcoholics with poor employment records, nearly all have emotional and psychiatric problems, and the majority have police records. Whereas most are misdemeanants, many have been arrested for felonies. In addition to being generally uncooperative, members of this group have upon numerous occasions threatened severe violence to nurses, physicians and other personnel in the hospital and clinic.

The recalcitrant patient is in need of psychiatric services. The present facilities at San Francisco General Hospital are unable to handle this added burden. It is our medical opinion that these patients require prolonged therapy in the hospital and in the clinic. There are presently 200 patients in this group. In addition, there are others who would benefit from shorter psychiatric assistance. We are of the opinion that a psychiatrist assigned to the Chest Clinic, serving part of the time with hospitalized patients, and then following them in the clinic, would solve many of these problems.

The second unmet need is a male investigator to locate the recalcitrant patients when they leave the hospital and return them to medical care. Presently there are twenty-four of these individuals with infectious disease, who are lost to medical supervision and cannot be located by the Public Health Nurse.

Since 75% of treatment is given to non-hospitalized patients, the work of Tuberculosis Control and the Bacteriology Laboratory have been increased. The two problems responsible for this increase is the development of drug resistant tubercle bacilli in the lesions which are no longer affected by the usual anti-tuberculous medications; and the necessity of determining communicability and confirming the diagnosis solely by bacteriologic techniques.

The development of resistance to anti-microbial agents is of serious import to the patient and to the community. The tubercle bacilli found in the lesions of these patients are no longer affected by the usual medications. This means that these



patients have a type of tuberculosis for which there is no cure. If these patients were allowed to spread this form of the disease in the community, we would soon have an epidemic for which there would be no treatment except prolonged hospitalization. We would then be back to where we were prior to 1952.

Resistant organisms develop more readily in old extensive disease and in patients who interrupt their course of treatment for any reason. Uncooperative and recalcitrant patients comprise the largest portion, but not all of this group.

Legally and medico-legally, bacteriologic confirmation is necessary to determine communicability and to establish the diagnosis. In order to adequately control tuberculosis and to present evidence which the Courts will accept in Quarantine and Isolation cases the newer bacteriologic tests must be done. Furthermore, frequently repeated sensitivity tests must be done to detect drug resistance early. The laboratory has been most cooperative and helpful. However, there is inadequate equipment and media to do the number and types of tests which are medically indicated.

With the decrease in serious complications and death due to tuberculosis, patients are living long enough to die of other diseases. Frequently, patients are seen at the clinic with other serious medical problems relating to the chest or to the medications. There is not available necessary laboratory facilities to properly evaluate and treat these conditions. In such cases it is necessary to hospitalize the patient in order to obtain a complete blood count and urine analysis - a ten dollar procedure in a private laboratory.

Furthermore, there are numerous indigent patients with advanced intractible emphysema and asthma, who cannot afford private clinic care, who are treated at Chest Clinic. The incidence of chronic emphysema is on the rise. In the very near future it will be necessary to expand and develop laboratory, pulmonary physiology, and treatment facilities to care for these people. Permission to use the clinical laboratory facilities at San Francisco General Hospital, when the new Laboratory Building opens, will solve many of these problems.

In reviewing the final statistics for tuberculosis for 1958 we found that only 26.7% of all of the newly diagnosed cases were reported by private physicians and private hospitals. Whereas in contrast 21% were reported by Federal Agencies and the remaining 52.3% were reported by the Tuberculosis Division of the Health Department. Many private physicians are not reporting the disease until it has become inactive under drug therapy. This type of newly reported case is never tabulated in our statistics, although the Health Department gives the same services to them as to the case which is reported while active.

Comparing the areas of highest incidence for 1958 with those of 1934, 1935, and 1936, it was found that there had been no change in these reservoirs in 25 years. Tuberculosis is found chiefly in the older parts of the city; with 88.8% of the new cases living in the eastern half. After 25 years, census tracts A and J and Skid Row still yield the highest number of new cases. These are poor socio-economic districts, with over-crowding, poorer living conditions, and minority groups. Uncooperative, and recalcitrant patients, hiding from the Health Department, are readily lost, or located only with difficulty, in these sections of the city. Case-finding programs have been directed at this group and these areas, but a male investigator would increase the productivity.

The casefinding programs of the department have been functioning at maximum capacity for a number of years. Chest Minifilm Survey Units at 101 Grove Street, San Francisco General Hospital, and the County Jail have had a productivity higher than state or national averages. This has been the result of interested and cooperative personnel. The School Tuberculin Skin Testing Program has been accepted generally as one of the better programs in the country. Our greatest need lies in expanding the services and facilities at the Chest Clinic. This will result in better patient care, at a lower total cost, with a better overall and more productive general program.





DIVISION OF VENEREAL DISEASE CONTROL

	<u>1954-55</u>	<u>1955-56</u>	<u>1956-57</u>	<u>1957-58</u>	<u>1958-59</u>
Total Patient Visits	21,518	21,051	20,938	22,808	25,902
New Patients Admitted	3,942	4,328	4,441	4,301	4,605
Readmissions	1,805	2,311	2,115	2,404	3,109
Newly Diagnosed Cases	1,389	1,492	1,818	2,088	2,872
Syphilis	169	246	275	333	449
Gonorrhea	1,220	1,236	1,543	1,752	2,418
Other Venereal Diseases	39	10	-	3	5
Laboratory Tests	20,608	22,749	25,283	31,044	35,614

(Note: V.D. Clinic at 101 Grove St. was closed on 9-1-58, concentrating all the above activities at City Clinic.

One aspect of venereal disease control is maintaining a clinic facility for case-finding, diagnosis, treatment and epidemiologic investigations. The above table shows the increasing activities along these lines in the past 5 years. Diagnosed and treated cases have more than doubled, laboratory specimens handled and/or tested have increased 75% and patient visits are up 25%. During the same period of time, all components of the staff, professional and other, available for program activities, have been reduced. To meet this increasing load with a smaller staff, we have been forced to compromise the quality of care which may be reaching dangerously low levels.

In accomplishing the above, the other facets of venereal disease control activities, education and public relations, have been reduced to a minimum. Such activities are usually carried on by supervisory personnel who now find most of their time occupied in routine clinic operation. (In cities of over 100,000, San Francisco currently has the highest rate of early infectious syphilis in the country.) Any program expansion in the area of case-finding, would require additional staff in the epidemiologic section plus clerical and nursing assistance.

Certain mechanization is thought desirable to secure maximum utilization of staff time. Two electric typewriters and a small telephone, visual K.T. system are requested to accomplish this goal. In addition, the Division has found the telephone directory organized by address, indispensable in its epidemiologic activities. In allocating monies for drugs and supplies, full cognizance should be given to the increasing activities reflected in the figures above. It is anticipated that such monetary requests may be increased as inventories accumulated over the years are reduced and/or become obsolete.





## BUREAU OF MATERNAL AND CHILD HEALTH

The Bureau of Maternal and Child Health is responsible for those programs in the Health Department dealing with the health of expectant mothers and the preventive medical services from infancy through school age. The divisions and programs of the Bureau include the Dental Division, Mental Hygiene Division, Crippled Children Services Program, Diagnostic Centers for hearing, vision and cardiac problems, childhood tuberculosis followup, school health program for both public and parochial schools, child health conferences, immunization centers, and maternal health services including classes for expectant parents.

### PERSONNEL

There have been no increases in personnel in this Bureau during the last fiscal year with the exception of three positions allowed in the Mental Hygiene Division under the Short-Doyle Program. The breakdown of personnel assigned to each division will be enumerated in the following pages before the description of each service, with the exception of physicians and administrative personnel.

There are 624 hours a week of physician time budgeted, including the administrative time of the Director of the Bureau. There have been no increases in physician time since the 1949-50 budget. Since that time, the school population has increased by over 30 per cent. In addition, the full-time physicians in the Bureau have been assigned as District Medical Officers in the nine district health centers. This means that approximately two half-days of each physician's time must be devoted to administrative time in the health centers while the rest of their time is spent in clinical work in schools and child health conferences. This results in more efficient administration of the health centers but takes away some of the clinical time which would otherwise be available.

The Director of the Bureau is responsible for program planning and evaluation of all of the programs mentioned above and in addition, must devote much time to community committees in order to insure that the Maternal and Child Health programs meet the needs of the children in the community and are integrated with other already existing programs. The time of the one clerk-stenographer budgeted to this Bureau for administration is inadequate for all the clerical work necessary.

### SCHOOL HEALTH SERVICES

The school population in San Francisco has increased steadily during the last ten years. In 1948 the school population was 89,167 while in 1958 the school population was 123,618; an increase of 34,451 or 35 per cent. The Statistics Division of the Unified School District estimates that the school population will continue to increase at the rate of about 5 per cent per year for the next few years. The amount of work to be done by public health nurses and physicians in the school health program has increased, not only due to the increase in school population, but also due to the changing social characteristics of the families.

It is estimated, for instance that the proportion of children in minority racial groups has increased from 13.6 per cent in 1950 to about 20 per cent in 1959. It is also known that the number of children receiving Aid to Needy Children has increased steadily during the last ten years. During the fiscal year 1950-51



the monthly average number of children receiving aid was 5,683 compared with 10,143 in the spring of 1959. These figures give some indication of the increased need for public health services to school-age children, since most of these children in the minority groups and low socio-economic groups require a large number of health services from our Department. This increase of children with increased health needs is not confined to one health center district, but is found in every district in San Francisco. Since a large number of the more stable economically independent families have moved from San Francisco to the suburban areas, it is necessary for us to provide a more comprehensive school health program for our school population than would be required in most suburban communities.

We recommend that children be examined either by their own private physician or clinic, or by one of the physicians from our Bureau, when they start school in San Francisco and every three or four years thereafter. Priority in scheduling children for examination is given to those children with special health problems referred by school personnel or parents. Each child also receives a tuberculin test when he enters school and again in the 7th, 10th and 12th grades. 18,240 tuberculin tests were given in the schools in 1958.

Every effort is made to refer children to their own private physician or clinic for examinations. The number of forms returned to us from private physicians has increased from 4,477 in 1955 to 22,897 in 1958. During the same period, the number of examinations done by our own physicians has increased from 16,737 to 28,089. Between private physicians and our own Health Department physicians, 50,986 children were examined in 1958 compared with 41,429 in 1957 and 21,214 in 1955.

In addition to examinations in school, the physicians in Maternal and Child Health are very active in community education and health education work. Each medical officer tries to meet with the faculty of each public and parochial school about once a year to discuss the importance of teacher-observation in health programs and the reasons for restriction in activity for children with special health problems. In addition, many of the full-time physicians, as well as the Director of the Bureau, speak to Parent-Teacher Association groups during the school year and also give talks on health subjects to students, particularly at the high school level. These group talks to students, parents, and teachers are a very important part of the total school health program, but the results are difficult to measure statistically. In 1958 school physicians conducted 2,992 group talks or individual conferences.

A great deal of time has been devoted by the Director of the Bureau, the school nursing supervisors, and many of the other physicians in the Bureau, to the development of a comprehensive school health manual. With the turnover in personnel, both physicians and nurses, it is extremely important that a school manual be available which outlines clearly the procedures for all of the school health programs such as vision screening, hearing testing, tuberculin testing, physical examinations, etc. Several sections of the manual have been distributed and the final sections are in the process of being completed. It is hoped that by the fall of 1959 all of the sections of the manual will be distributed. A project of this kind takes many hours of administrative time, nursing time, time of school personnel and, particularly, clerical time. It is during the development of such projects that we become especially aware of our shortage of clerical help and our lack of modern duplicating and reproduction equipment.



## CHILD HEALTH CONFERENCES AND IMMUNIZATION CENTERS

During 1958, 44,421 children were seen in the Health Department child health conferences. This is 558 fewer children than were seen in 1957, but does not represent a decrease in service because of the fact that many preschool children are now referred for completion of their immunizations to one of the immunization centers. This is done in a conscious attempt to cut down on the average number of children seen per session in each child health conference in order to be able to devote more time to those parents and children who need more counseling and guidance. Even with this decrease, an average of 24.77 children were seen during each three-hour conference session last year. This is an average of over eight children an hour, or less than eight minutes per child. Obviously, eight minutes is a very short time for a physician to spend in examining a child, discuss feeding, growth and development, and still have time to help the mother with any special problems which she may have in relation to caring for the child. If adequate time for counseling and guidance by a physician were to be allowed, each child should be allotted a minimum of 10 to 15 minutes, which would cut down the average attendance per session to between 18 and 20 children. The child health conferences, as presently organized, are able to function satisfactorily only because of the large amount of public health nursing time devoted to follow-up after the physician has seen the child. The public health nurse does much of the followup and interpretation of health findings which would be done by the physician if he were able to spend more time with each mother.

During 1958 a new testing procedure was instituted in the child health conferences. This is the use of ferric chloride solution by the physician for testing wet diapers for Phenylpyruvic acid. This test is important for the early detection of a specific type of mental retardation. If the test is positive, the child can be placed on a special diet which has proven successful in preventing the retardation.

During 1958 one new child health location was opened in the Hunters Point District in one of the cottages of a public school. This has been very successful because the residents of this area were unable to reach the Hunters Point Health Center due to the difficult transportation in that area.

Immunization centers are conducted once a week in each of the nine district health centers. Both preschool and school-age children may receive immunizations against diphtheria, whooping cough, tetanus, smallpox, polio, and may be given tuberculin tests. The attendance at these centers has shown a tremendous increase during the calendar year 1958 and an even more marked increase in the spring of 1959. In 1958 the total attendance at the immunization centers was 30,829 children compared with 9,945 children in 1957. During the calendar year 1958, a total of 90,232 immunizations and tests were given in the immunization centers and child health conferences compared with 65,444 in 1957. The breakdown of the number of immunizations of each kind is given on the table following this report. The marked response of the public in using these immunization centers has been good from the standpoint of increasing the immunization level of our San Francisco children. However, this necessary service requires more funds for personnel, biologics, and materials and supplies, if it is to be continued.

## MATERNAL HEALTH AND CLASSES FOR EXPECTANT PARENTS

The total number of births in San Francisco decreased during 1958; however, almost 200 more babies were delivered at San Francisco General Hospital in 1958 than in 1957. Of the 1,731 births which occurred in San Francisco General Hospital in





1958, 287 were premature. The rate of premature births, although still higher than for any private hospital in San Francisco, was lower in 1958 than in 1957, and represented 16.1 per cent of the total deliveries. At the rate of \$24.49 a day, the cost of hospitalization for the 188 premature infants who survived was \$100,360. There is a great need to make a study of this problem at San Francisco General Hospital in order to try to pinpoint some of the causative factors. It is only through such basic research that we can hope to develop a preventive program and reduce some of the cost of this premature care as well as the cost to the community of caring for the large number of health problems which these prematures develop as they grow up.

The health centers participated in the followup study of possible staphylococcal infection of all new-born infants discharged from San Francisco General Hospital, which began in May 1958. The control of staphylococcal infection in hospitals in general, and nurseries in particular, is a problem of nation-wide importance at the present time, and one of which all Health Department personnel are aware.

During the year 1958 classes for expectant parents were conducted in four health centers. The medical officers in these centers actively participated in several of the sessions and assisted the public health nurses who conducted the classes as much as possible. In general, the women who are interested in attending these classes are from the middle or upper economic and educational levels of the community. The classes serve a real educational need for those who attend; however, they require a great deal of staff time, not only in conducting the classes, but primarily in preparing to conduct the class and getting out advance publicity, etc. Other community agencies such as the Red Cross, the Y.W.C.A., and several of the voluntary hospital clinics are now providing similar classes. We may be forced to discontinue these classes in order to devote staff time to other problems more acute.

Of the mothers who delivered at San Francisco Hospital, 27 per cent of the white mothers and 14 per cent of the Negro mothers had no prenatal care in spite of much effort by the public health nurses in the districts to get these women under care early. Almost 50 per cent of the mothers who delivered at San Francisco General Hospital were single, separated, or divorced, and others presented serious problems of social disorganization. In view of these facts, coupled with their high rate of premature deliveries, it is possible that some of the time devoted to prenatal education in the classes for expectant parents may be devoted to these women delivering at San Francisco General Hospital who represent such high risks in terms of the outcome of their pregnancies.

#### CRIPPLED CHILDREN SERVICES

Personnel:	1 - Administrative Assistant
	2 - Medical Social Workers
	1 - General Clerk-Stenographer
	5 - General Clerk-Typists
	1 - Clerk I

For about half of the year 1958, one of the full-time District Medical Officers was assigned part of the time to assist in the Crippled Children Services Program. Since this person resigned to become full-time Medical Administrator of the Crippled Children Services Program in another county the same size as San Francisco, the only medical direction for the program has been given by the Director of the Bureau. A medical care program the size of our Crippled Children Services Program requires approximately half of a physician's time in order to make the necessary medical decisions and maintain contacts with the physicians





and hospitals in the community with whom the program deals. The Administrative Assistant has functioned extremely well during this period of physician shortage but should be relieved of more of the medical responsibilities.

During the last year, the Administrative Assistant has analyzed the activities of the division in order to make the processing of cases as efficient and functional as possible. She has also organized the entire filing system and established a new filing system for administrative material.

There has been a marked increase in the number of new cases referred from private physicians in the past two years. In the first six months of 1958, 584 new cases were referred, compared with 648 referred during the first six months of 1959. The total number of active cases as of July 1, 1959, was 2,776. All cases which are not under active treatment have been closed; therefore, this represents cases which require constant clerical work, administrative review, etc. During the fiscal year 1958-59, the total expenditure for Crippled Children services was \$392,692. Since the reorganization of the Crippled Children Services Program, which began in 1955, the average cost per child treated under the San Francisco Crippled Children Services Program has dropped from the highest cost in any individual county to the lowest cost in any individual county. This has been done primarily by close control of the cases under care and good organization. During the last year, the families of the patients under the San Francisco program have reimbursed the City and County of San Francisco \$24,255. This money is credited to the general fund. Another method which has been employed to cut down the expense of each case is by collecting more extensively for services from insurance companies which cover the families. This has resulted in a great saving to the City and County, but the amount has not been recorded. Another means of saving money for the Program is through the establishment of a blood bank to which relatives and friends of children cared for under the Program may contribute. During the fiscal year 1958-59, 153 pints of blood were credited to the San Francisco Crippled Children Services Program. At \$25 a pint, this represents a saving of \$3,825 to the Program.

Budgetary increases in the Program will be necessary during the next fiscal year due to the addition of new medical categories to the Program which will be very expensive to treat. Nephrosis becomes an eligible condition as of October 1, 1959. Epilepsy will become an eligible condition sometime during the coming year after a pilot program has been started in two counties in the State. It is anticipated that the care of acute polio will be the responsibility of the Crippled Children Services Program if the San Francisco Foundation for Infantile Paralysis runs out of funds as have the other polio foundations in other counties in California.

The Director of the Bureau has been involved during the past year in a community committee set up to study the needs of cerebral palsied children in San Francisco. Further analysis of the unmet needs in San Francisco for care of these children will be done during the next year. It may be necessary to request additional personnel and/or funds to meet the medical care needs of these children.

The personnel needs of this program continue to be:

- (1) The need for a Senior Clerk to organize and supervise the workload of the clerical staff.
- (2) Part of the time of an Assistant Director of Maternal and Child Health to be spent in medical administration and supervision of the Program.



## DENTAL DIVISION

Personnel:           1 - Chief, Dental Division  
                  10 - Dentists - half time  
                  4 - Dental Hygienists  
                  1 - Dental Assistant  
                  1 - Clerk-Typist - 13½ hours per week

The dental division program is divided into two main phases: (1) Dental education for preschool and school-age children and (2) Oral prophylaxis and operative dentistry for indigent preschool and elementary school children. Four of the half-time dentists work in the Central Dental Clinic at 101 Grove Street; the rest of the part-time dentists are assigned to 7 district offices. The waiting list for children requiring prophylaxis and operative dental care continues to be quite long. Dental disease is common to almost 100 per cent of all school children and is particularly common in children in the indigent groups which we serve.

During 1958-59, a total of 25,395 visits were made to the dentists in this Bureau. This is 3,394 more than in the previous year. Statistics on all aspects of operative dentistry increased markedly in the fiscal year 1958-59, compared with the fiscal year 1957-58.

The four dental hygienists carried out dental education in 62 public schools and gave classroom talks to 199 classrooms. Over 6,000 children were given dental education during these talks. The hygienists gave oral prophylaxis to 5,241 children. Since four hygienists are unable to cover all 203 public and parochial schools, a cooperative program with the University of California School of Dentistry was developed. In this program, 1,080 third-grade students from parochial schools visited the University of California School of Dental Hygiene and received dental education and prophylaxis. In addition, classroom talks were given to a total of 317 classrooms of children in public and parochial schools from kindergarten through the 8th grade. By cooperating in this manner, we were able to provide teaching material for the University of California Dental Hygiene students and dental education for many more children than would have been possible for our four hygienists working alone.

It would be valuable to increase the scope of the preventive aspects of the dental program, particularly by working with parents of preschool children in the child health conferences and with young elementary school children. This could be done in both the educational and operative aspects of the total dental program. The treatment aspects of the program are not a true function of a preventive dental program in a health department; however, at the present time, there are practically no facilities for large families in the lower and middle income brackets; therefore, it is necessary that some public agency provide a resource for dental care for these children. Since this responsibility has been placed on the Health Department, it is urgent that more dentists be added to the staff in order to be able to treat more children and cut down the waiting time between appointments.

Some of the dental chairs and other equipment are extremely old and should be replaced gradually in order to cut down expensive repairs. Four of the dental units at 101 Grove Street are almost 30 years old. Because of the increased number of children being treated, more materials and supplies must be used each year. Supplemental appropriations have been necessary in the past in order to keep the dentists supplied with materials throughout the fiscal year.



## MENTAL HYGIENE

- Personnel:     2 - Psychiatrists (These are 2 full-time positions presently filled by 5 part-time Psychiatrists)
- 1 - Senior Psychologist
  - 3 - Psychologists - full-time
  - 1 - Psychologist - part-time
  - 3 - Psychiatric Social Workers
  - 2 - General-Clerk-Stenographers - full time

The positions of 1 full-time Psychiatrist and 2 Psychiatric Social Workers were added to Mental Hygiene Division budget in April, 1959 under the Short-Doyle funds.

Beginning on April 1, 1959, the cost of half of all of the personnel required to treat the voluntary patients in the Mental Hygiene Child Guidance Clinic has been reimbursed to the City by the State under the provisions of the Community Mental Health Services Act. This has made it possible to expand services to patients and will help provide time to develop and implement new mental health programs in the health centers, child health conferences, etc. The types of service offered by the Mental Hygiene Division include:

1. Routine child guidance clinic work. This includes the diagnostic evaluation of children with emotional problems. Both the child and his parents are seen in order to provide this evaluation. During the last year 746 families were evaluated, compared with 676 families in the fiscal year 1957-58. After the family has been evaluated, the case is either carried by this clinic for immediate emergency treatment or referred to another agency for treatment if the staff time does not permit this clinic to carry the case. In July of 1958, the Mental Hygiene Division began a new short-term treatment program for psychiatric emergencies which has been unavailable elsewhere in the community. In most child guidance clinics in the City, the waiting time before treatment can be begun is from six months to two years. This program of offering immediate short-term treatment has proved to be effective, economical, and seems to meet a definite need for those families requiring immediate service because of some emotional crisis. In addition to the individual therapy, the clinic also offers a group therapy program for mothers.
2. Work with mentally defectives. This work involves primarily the processing of mentally retarded children for placement in Sonoma State Hospital. It includes the psychological evaluation of the child, preparation of commitment papers, correspondence with Sonoma State Hospital, support and guidance of the parents during this period of time, and consultation with other agencies. At the present time, there are 83 applicants to Sonoma State Hospital on our waiting list, compared with 160 children who were on the waiting list of July, 1958. This commitment activity takes approximately one-quarter time of one of the staff psychologists. Since Sonoma State Hospital maintains its own diagnostic and pre-admission service and duplicates many of the casework procedures carried on by our unit, it seems appropriate that the possibility of transferring much of this work to some other agency of government should be considered. This would free more staff time to devote to case work services and therapy which is so badly needed by the parents of these retarded children. They often wait for many years before their child is accepted by Sonoma. Therapy and casework services are also





needed by many families with retarded children who do not wish to hospitalize their child. We are now reviewing this program and may discontinue this service.

3. Consultation Program. The Mental Hygiene Division provides consultation to the staff of each of the nine district health centers on a regular basis, approximately one-half day a week. This program is becoming more accepted by the health centers and the consultants are well used by the public health nurses and physicians for difficult cases.

4. Miscellaneous services of the Mental Hygiene Division include consultation to community groups, educational activities such as lectures, films, etc. to P.T.A. groups and teachers. The Division also provides extensive psychological testing and evaluation of pre-school and school-age children. Approximately 700 psychological tests are given each year. Most of the school-age children who are tested are handicapped children such as blind, deaf, cerebral palsied, etc. This service is provided as part of our total school health program.

Plans for extended services in several preventive fields during the next year are being formulated at the present time. These include participation of one of the psychiatric social workers as a member of the child health conference team in one of the health centers in order to help focus on the mental health aspects of parent-child relationships with the hope of picking up disturbed family relationships as early as possible. It is also hoped that time can be spent in helping to develop a more coordinated community approach with provision of psychiatric services to selected unwed teen-aged pregnant girls. If the Division is able to give up some of the work of the routine commitment processing, it is hoped that some specialized counseling or group therapy for parents of mentally retarded children can be developed.

The primary unmet needs of this Division at the present time are: Office space for the new workers and dictating and transcribing equipment so that the time of the professionally trained people need not be devoted to writing up cases in longhand.

#### EYE AND EAR CENTERS

During 1958, 2,879 children were seen by the Ophthalmologist in our Eye Diagnostic Center. All of these children are referred by a public health nurse, parent, school doctor, or community agencies because the child is suspected of having poor vision. Each child is examined by the ophthalmologist. If he is found to need eye care, he is referred to his private physician, clinic, or through the Crippled Children Services Program for the care which is necessary. Of the children seen during 1958, about 84 per cent were referred on for further care. When a child is referred for followup, the public health nurse in the school is informed of the recommendations and follows up with the parent until the care is obtained. As an example of the kind of follow-up which occurred - in January 1959, 72 of the children examined in the Eye Diagnostic Center were referred for refractions. Six months later, as of July 1, 1959, 60 of these children had obtained glasses; 5 more were under medical care for their vision problem, but their physician felt that glasses were not indicated; another 5 children had obtained prescriptions for glasses and were in the process of obtaining them; 2 children had graduated or moved away before the followup could be completed. Thus 70 of the 72 children referred had been seen by their eye examiner and were under care.





The attendance at the Ear Diagnostic Center dropped during 1958 because of the difficulty in obtaining an otologist to examine the children and because one of the three audiometric positions were unfilled from September 1957 until October 1958 (10 months of the 1958 statistics). 1,677 were seen (130 less than in 1957).

The objectives of the hearing testing program and Ear Center follow-up are to find children with impaired hearing, furnish the medical diagnosis, initiate medical and educational corrective measures and prevent further hearing loss whenever possible. All children in San Francisco public and parochial schools receive a hearing test approximately every three years from the third grade up. Those children who fail to pass the group hearing test receive an individual hearing test in the school. If they fail to pass the individual hearing test, they are referred for another test and ear examination to their private otologist or to the Health Department otologist at 101 Grove Street. During 1958 a total of 39,769 tests were given, compared with 47,265 tests given in 1957. As mentioned above, this decrease in the number of tests was due to the fact that one of the three audiometrist positions was vacant for ten months of 1958. No new audiometrist has been added to the budget since 1948. During this time, the San Francisco school population has increased by over 30,000 students. If the hearing testing program is to remain at the present level, another Audiometrist must be added to the budget. It is recommended that hearing testing begin at the first-grade level rather than at the present third-grade level in order to identify those children with hearing loss at a younger age. If this is to be done, it is even more urgent that a new Audiometrist be added to the budget since the testing requires more time for younger children.

#### CARDIAC DIAGNOSTIC CENTER

During 1958 a total of 346 children were seen in the Cardiac Diagnostic Center. This number remains about the same each year. The Cardiac Center is an extension of the diagnostic screening facilities of the Child Health Conference and School Health Program. Children who are referred receive a chest x-ray electrocardiograph, laboratory work and a physical examination by a cardiologist. If further examination is required such as cardiac catheterization, the child is referred through the Crippled Children Services Program. The Cardiac Diagnostic Center, as well as the Eye and Ear Diagnostic Centers in this department, are thus a part of the total Maternal and Child Health case finding and diagnostic program, rather than strictly Crippled Children Services clinics as is the case in surrounding counties.

Of the children seen in 1958, 27 were definitely found to have organic heart disease and in addition, 123 were found to have heart murmurs which required further investigation.

One of the physicians in the Cardiac Center supervises the medical aspects of the Cardiac Registry. This Registry is a unique activity of a health department. The names of all children with known congenital heart disease or rheumatic fever are recorded. For the school-age group, the Registry is very complete since all private physicians' letters to the schools and Crippled Children Services records are routed through the Registry on the way to the Public Health Nurse in the school. In addition, the school nurse reports yearly which children in the school have known heart disease. An appraisal of certain aspects of the Registry is planned during the next year. Since all children with known rheumatic fever are registered, it would be valuable to know how many have been prescribed prophylactic penicillin and, of these, how many are actually taking the penicillin. Since it is known that prophylactic penicillin can prevent recurrences of rheumatic fever, this will provide valuable information on the need for further professional or community education.



It is also planned to review the known cases of congenital heart diseases to determine how many have had a complete diagnostic work-up including catheterization and whether corrective surgical procedures are now available for these children. The Registry is of value to the community only if it can be utilized in giving some of the answers to these questions; however, such an analysis takes both clerical and statistical time which is at a premium.

#### CHEST CENTER

The three main functions of this Center are: X-raying of school children with positive tuberculin tests; conducting medical conferences on selected children with positive tuberculin tests, and the statistical follow-up of the School Tuberculin Testing Program. During 1958, 7,150 X-rays were taken of children - this is an increase of 1,363 over the previous year. 580 children with 3 and 4+ tuberculin reactions were seen in medical conferences during 1958. This medical conference consists of a medical history, physical examination and an interpretation of the chest X-ray to the parents by the physician. Children whose tuberculin tests have recently converted to positive or whose chest X-ray or examination indicates the need for further care, are referred either to their private physician or to the Chest Clinic for further follow-up. The physician who conducts the medical conferences also does all of the school tuberculin testing and reading in the junior and senior high schools and reads all of the chest X-rays on children who have positive tuberculin tests. The tuberculin tests on elementary school children are given and read by the health officers in the districts.



## BUREAU OF PUBLIC HEALTH NURSING

The staff of the Bureau of Public Health Nursing gives generalized nursing service according to the needs of the various programs planned and directed by the Director of Public Health, his assistant, and the medical program chiefs.

The Public Health Nursing Staff is assigned to nine district health centers. Although variation in health problems occurs in the different districts, each nurse is responsible for the health needs of families living within her respective district. Each district is subdivided according to the number of nurses assigned. This is determined by population, health needs, and fixed activities to be covered such as child health conferences, schools to receive service, disease incidence, etc.

### PERSONNEL

No new employments have been added to the Public Health Nursing Bureau since July 1, 1956. The staff consists of:

- 1. Director
- 1 Assistant Director
- 1 Educational Director
- 16 Supervisors, Public Health Nursing
- 127 Staff Public Health Nurses  
(3 paid by Child Care Centers)
- 15 Clerical Workers  
(17 budgeted but 2 are assigned to  
Bureau of Maternal and Child Health  
at the order of the Director of  
Public Health)
- 7 Porters

The present method of training public health nurses, current throughout the country, does not provide us with mature, experienced new nurses and training of this personnel is an increasing problem

### MATERNITY PROGRAM

Developments in the Maternal and Child Health Program have been:

Administration of phenylketonuria tests to infants in the child health conferences.

Investigation of staphylococcus infections on all newborns and their families discharged from San Francisco General Hospital.

This entailed inspection of infants and completion of questionnaires in addition to the instructional service routinely given. Closer supervision of premature babies, with improved communication between the field and the hospital, has been effected.

The percentage of unmarried mothers continues to be high. It is noteworthy that negroes represent only seven percent of the population of the city, but forty-eight per cent of the unwed mothers are from this minority group.

Child health conference attendance was 44,979 in 1957 compared to 44,421 in 1958, a decrease of 558; however, immunization center attendance increased spectacularly from 9,945 in 1957 to 30,829 in 1958, an increase of 20,884. Increased demands for nursing service is reflected in these activities.



### SCHOOL NURSING PROGRAM

Total school population has gone from 114,526 in 1957 to 118,046 in 1958, an increase of 3,520. Every child is given a physical evaluation on entrance to school, and at the 4th, 7th and 10th grade levels, accompanied by a tuberculin test. Other aspects of school nursing include defect follow-up, vision and hearing screening, service to handicapped and emotionally disturbed children, first aid, counselling of parents and children.

### COMMUNICABLE DISEASE CONTROL PROGRAM

A total of 33,864 Public Health Nursing visits were made to tuberculosis cases or their contacts, an increase of 1,257 in 1958; 2,052 families are receiving nursing supervision. A total of 26,912 tuberculin tests were done, yielding 1,686 positive reactors or 6.3%. Nursing follow-up was done on all.

The Venereal Disease Treatment Center formerly located at 101 Grove Street was combined with the City Clinic at 33 Hunt Street. The generalized district formerly known as South of Market, and housed at City Clinic, was combined with the Central Health Center and moved to the premises vacated by the Venereal Disease Division. It adapts itself to better service for the people and has resulted in better working conditions for the staff.

### STUDENT PROGRAM

The Student Program gave field instruction to thirty-eight nurses from the University of California -- some graduates, but the majority basic students receiving public health nursing experience during their collegiate nursing training. It varied from periods of eight weeks to several months, according to individual needs.

Observational experience of one week's duration in the health centers was given to ten Chico State College nursing students receiving their clinical experience at the San Francisco General Hospital.

Plans are underway to give field experience to nursing students from the University of San Francisco this Fall of 1959. Each university will be assigned certain health centers and their instructors will share one office with the Coordinator of Volunteer Services.

### MENTAL HEALTH PROGRAM

The Mental Health Program made progress in consultation services. Considerable staff time was involved in individual conferences and in group meetings with health center staffs.

### STAFF EDUCATION

Staff education was planned by a Department Education Committee, chaired by the Educational Director. Three general staff meetings were held in the Auditorium at 101 Grove Street related to the subject of "Maternal and Child Health". This was the expressed need and wish of the staff. In addition, the Director of Public Health spoke to the entire nursing staff and this was the most well liked program of the year. It is hoped it may be repeated annually.

A half day in-service training program on "Safety and Home Accident Prevention" was conducted for medical, nursing and sanitarian staffs.







Ten nurses attended a five-day "Institute on Safety" at San Francisco State College.

Four supervising nurses and a staff nurse attended a three-day workshop on "Administration and Supervision" in Santa Barbara.

The Director of Public Health Nursing attended a two and one-half day workshop on "Public Health Nursing Administration" at Asilomar.

Recognition is given the progress some of the health centers have made in planning sound staff education meetings on district levels. The Department Education Committee is concerned with the uneven quality of some of the meetings and plans to direct part of their efforts to helping develop a sounder educational pattern more in accord with the needs of the daily work.

The Director of Public Health Nursing and the Educational Director met thirty-four requests from community groups such as the P.T.A., schools of nursing, and others who asked for speakers from this bureau. This is considered sound public relations activity and gives us an opportunity to inform the public concerning Health Department functions.

#### VOLUNTEER PROGRAM

The Volunteer Program continues to render invaluable help to our entire staff, led by Mrs. Gwen Valliant, an able and devoted Coordinator of Volunteer Services, and her assistant, Mrs. Mabel Juvet.

#### CLERICAL STAFF

The members of the clerical staff have held regular meetings, guided by the Educational Director, and have compiled an excellent manual which should result in uniformity of work methods throughout the bureau.

#### IN-SERVICE TRAINING

Plans are made to conduct a different type of orientation program for the seventeen new nurses who have been employed during the summer. They will spend two days a week for six weeks in intensive training by the administrative nurses, the specialized supervising nurses, and the program medical chiefs. Three new district medical officers will participate in parts of it which are of general interest.

#### RECOMMENDATIONS AND FUTURE PLANNING OF HEALTH CENTER ACTIVITY

During the past year a start has been made on developing the individual health centers as a decentralized operating unit of the department. With the coming year each of the nine health centers will have one full-time medical officer in charge of the center.

As will be seen by the reports of the Bureau of Public Health Nursing, much of the work of these two departments overlaps and is performed jointly by the members of the nursing staff and the medical staff. As the public health centers develop, more planning for the particular community in which the center is located will be done by the members of the staff in the center who are on the job and know the individual problems of their community. Insofar as the health centers are concerned, the line and staff type of organization will be in effect. The Central Office staff people will act as planners, consultants and distributors of personnel and service while the actual operation will be carried out by the line portion of the



department operating in the health centers. It is, therefore, logical to discuss the departmental needs for the health center services provided for both departments under a combined heading:

- (1) The number one need of the health centers is erection of permanent quarters in the Eureka-Noe, Westside and the Marina-Richmond districts. The quarters in those particular areas are inadequate in size and facility.
- (2) The introduction of mechanical tabulation for data in the Nursing and Maternal and Child Health Divisions is of utmost importance from the standpoint of both efficiency and economy.
- (3) The development of a complete Central Supply Unit must be carried forward promptly. The coordination and requisitioning of supplies should be completely standardized and centralized.
- (4) Progress must be continued on the revision and preparation of the general health center manual.
- (5) Utilization of the Statistical Division to coordinate and organize the collection of statistics from all divisions of the department should be planned and executed without delay.
- (6) The mechanization of bookkeeping and clerical procedures is of utmost importance. The health centers should have adequate access to adding machines, comptometers and similar equipment. Much time is wasted in the Central Office because of the necessity to hand cut paper, punch holes by hand and retype copies of letters when additional copies are needed.
- (7) Budgets for equipment, printing, biologics and other supplies must be expanded if the present programs for immunization are to be continued.



## ADULT GUIDANCE CENTER

### I. Introduction

The Adult Guidance Center, in April, 1959 began its ninth year as a voluntary medical psychiatric outpatient clinic for the treatment of alcoholism. Since 1955, the Adult Guidance Center staff has expanded its program beyond treatment and rehabilitation to devote serious efforts in the traditional public health activity of prevention. This has entailed increasing staff activities in research and in community organization and education.

For the fiscal year 1958-59, the clinic budget of \$241,446.00 was reimbursed \$58,000 by the Division of Alcoholic Rehabilitation, State Department of Public Health, and approximately \$88,685.00 from State funds under the Community Mental Health Services Act. Research projects costing \$11,696 were financed by the Division of Alcoholic Rehabilitation of the State Department of Public Health.

### II. Services in the Clinic

Services provided by the Adult Guidance Center at 150 Otis Street:

<u>Fiscal Year</u>	<u>1957-58</u>	<u>1958-59</u>
Patients admitted to treatment	1,128	1,626
Total Patient Visits	30,525	34,086
Physician interviews, examinations and treatments	20,800	22,523
Registered Nurse interviews, administra- tion of prescribed medications	23,857	26,583
Individual Psychotherapy	4,920	4,105
Group Psychotherapy	1,708	2,574
Application Interviews	2,947	3,308
Other Services	805	783

Services provided by San Bruno Jail Clinic:

	<u>1958-59</u>
Jail Admissions (Drunk related)	3,879
Admissions seen by staff	1,908
Clinic Services:	
Psychiatric Social Worker	1,229
Psychological Testing	2,275
Physician interviews and treatments*	<u>1,661</u>
Total	5,155

\*Does not include medication supplied by clinic and administered by jail physicians to alcoholic prisoners



### III. Cooperative Projects

The clinic has been cooperating with seven Halfway Houses which have been developed by voluntary agencies in San Francisco, and accepts patients referred to it by them. During the past fiscal year, 229 such patients have been referred and treated at the clinic. The Clinic staff meets regularly with the managers of the various Halfway Houses to assist them in their problems related to the operation of such facilities.

The staff has also cooperated in seminars for the clergy of all faiths to aid them in counseling the alcoholic and members of the family.

In cooperation with the San Francisco State College, the Clinic provides an internship for second year graduate students in vocational counselling and rehabilitation.

### IV. Research Activities

A number of research studies are under way in cooperation with the Division of Alcoholic Rehabilitation of the State Department of Public Health. These studies involve investigations in the use of drugs, studies on psychological characteristics of the patients attending the clinic, and a differentiation of psychological characteristics found in clinic patients and patients seen at County Jail #2.

A further study is seeking information on some of the drinking patterns of teenagers.

### V. San Bruno Jail Clinic

The San Bruno Jail Clinic of the Adult Guidance Center has now been operational for over a year. With a staff consisting of a half-time psychiatrist director, a half-time psychologist, two psychiatric social workers, plus the aid of a correctional specialist working under contract sponsored by the State, the program has accomplished the following:

1. Set up and conducted (with the assistance of jail and V.C. Clinic physicians) a medication program for the treatment of alcoholics in acute withdrawal, both at the City Prison and San Bruno. This program, long overdue, has eliminated the old inhumane and ineffective methods of dealing with seriously ill people. Prisoners no longer "sweat it out" in acute hallucinosis or delirium tremens. This treatment has effected economy of time and effort on the part of the custodial staff as well as decreased their apprehensions in dealing with these people.

2. Set up and conducted a careful program of psychological testing for both clinical and research purposes. A highly informative objective test battery has been used to provide information on alcoholics and contrast groups. Test results are used in establishing treatment programs for the prisoners both in the jail and following discharge. Statistical analyses of test results have provided information highly useful in planning the general orientation of the program as well as in the treatment of individual patients. Over 1,100 patients have been tested to date, providing one of the largest samples of alcoholic offenders in the United States.





3. Set up and conducted a comprehensive inpatient treatment program at the County Jail, offering a wide spectrum of treatment ranging from analytically oriented short term psychotherapy through supportive therapy to casework dealing with immediate environmental problems on discharge. These are given a wide variety of patients referred by themselves, custody or other agencies. To date about 1,900 patients' have received treatment at the jail.

4. Set up and conducted a program for post-discharge care of prisoners including the use of all available community resources and particularly follow-up treatment at the Adult Guidance Center.

#### SUMMARY AND RECOMMENDATIONS

The first year of the Jail Clinic operation has been instructive and has shown that the alcoholic offender can be helped. Development of the pilot program into a full scale rehabilitative effort is contingent on public information and support.

Eventually, it is hoped that San Francisco will provide a dynamic comprehensive program based on a medico-psychiatric rather than custodial orientation in the treatment of these emotionally disturbed patients. The development of such a program will involve extensive cooperation by the courts, law enforcement agencies, and a great variety of voluntary and official agencies concerned directly and indirectly with the alcoholic. Ultimately, we hope that our program can deal to a greater extent with the thousands of "hidden" alcoholics in the population and perhaps develop a truly positive program aimed at our younger age groups.

#### NEEDS - The Clinic's most pressing needs are:

1. An adequate telephone system. Clinic efficiency is adversely affected by the totally inadequate telephone system.

2. Additional space, preferably the third floor of 150 Otis Street now occupied by record storage. The clinic operation is impeded by insufficient interviewing and treatment rooms; there is no patient waiting room; there are no rooms adequate for educational and group therapy activities except the director's office. Additional space will increase the efficiency of professional staff time and permit expansion of group therapy activities.

3. Pending the completion of the City job survey and analysis, we are not requesting the establishment of supervisory positions such as a senior clerk, head nurse, senior psychologist and supervising psychiatric social workers. The survey will doubtless reveal the need for such personnel.



## EMERGENCY HOSPITAL SERVICE

Over the years, the Emergency Hospital Service has crystallized into a well-organized and very well standardized operation.

With the practical stabilization of the population, the need for expansion has not been great. Thought should be given, however, to the rebuilding of the Park Emergency Hospital, which is almost seventy years old.

The ambulance crews have provided emergency care and transportation for approximately 35,000 people in the last fiscal year, which is in keeping with the annual operation for the past several years. There has been an increase in people applying directly to the Emergency Hospital Service for care from 92,000 last year to 112,000 this year.

The service works very closely with the Police Department, and provides transportation for the officers serving mental illness warrants, provides the blood testing for alcoholics, and at the request of the Police Department, examines cases of suspected rape.

In addition to these services, we have this year cooperated with the Police Department in the establishment of the Nalline testing program, and provided them with space for their operations. The Emergency Hospital staff at its Central office takes care of the sterilization of syringes and needles, and preparation of other materials for use in the program.

It is the intent of this department to request modification of the Charter which will give employees of the Emergency Hospital Service the same protection which is given to Police and Fire Department members in case of accident or injury while on duty.



### CITY PHYSICIANS SERVICE

The City Physicians continue to make home calls on the indigent persons on referral from the Division of Social Service at the San Francisco General Hospital or after 5:00 PM on direction from the Booking Steward at the Central Emergency Hospital. The following tabulation represents the individual calls made by the various City Physicians:

<u>Names of Physicians</u>	<u>FISCAL YEAR 1958-59</u>	<u>Number of Visits</u>
Dr. J. B. Giovinco	-	712
Dr. F. M. Jacks	-	880
Dr. R. M. Laddon	-	653
Dr. F. A. Moran	-	900
Dr. W. Waldeyer	-	554
Dr. G. Loewe	-	4,006
(examines City Employees and is the Admitting Physician)		
Dr. H. C. Bernstein	-	496
Dr. M. H. Long	-	258
Dr. A. E. Schmidt	-	241
Dr. W. F. Shaw (City Prison) (July, August & September, 1958)		1,120
Dr. N. N. Gray	-	496
Total Calls		<u>10,316</u>

The high load attributed to Doctor Loewe is due to the fact that he maintains an office at the San Francisco General Hospital and makes a very quick review on patients who are to be admitted to that institution. The data for the City Prison goes only to September, 1958 at which time the calls in the City Prison were absorbed by the doctor assigned to the City Prison from the Division of Venereal Disease Control who also continues his previous function of examining the female prostitutes for venereal disease. At the present moment no program has been set up to examine the male prostitutes for venereal disease and they are treated in a different manner at the Venereal Disease Clinic at 33 Hunt Street.

The calls for the fiscal year 1956-57 totalled 14,589 cases, and for the fiscal year 1957-58, 15,425 calls.



## HASSLER HEALTH HOME

1. The purpose, scope, and place of this institution's program and services in the Department's over-all program:
  - a. To provide definitive medical treatment for residents of San Francisco City and County suffering from tuberculosis in all its form.
  - b. To isolate individuals whose disease is in the infectious stage.
  - c. To continue custodial care for patients whose disease is considered inactive but who require custodial care until beds are available at Laguna Honda Home.
  - d. To rehabilitate patients with the idea of restoring them to their former occupation or a new occupation and a new way of life in a state of health which will benefit them by preventing reactivation of their disease.
  - e. To conduct a clinic for the Single Men's Rehabilitation Center of Public Welfare Department which is located at the foot of the hill on the Hassler Health Home premises. In addition, there are approximately forty ex-tuberculosis patients in the Center who require regular follow-up for continued treatment or observation.

### II.. Specific program activities accomplished, in progress, and contemplated:

- a. Medical and Nursing Service: One ward is used to take care of patients with inactive tuberculosis status, but who have some sort of physical disability which requires constant nursing supervision and care. At one end of this ward a combined recreation and physical therapy area is established.
- b. Arts and Crafts Program: This program has continued since October, 1957, with a teacher assigned by the City Board of Education. This activity should be expanded in order to help more patients. This program should be available to the patients for a longer period daily, and also for more days per week. Such expansion can only be accomplished by the establishment of a new position of occupational therapist, as well as a budget for purchasing of materials.
- c. Housing and grounds maintenance: With the help of the Department of Public Works several areas have been improved. Emergency exits leading from Wards VI-A and VI-B have been completed. These exits consist of ramps of sufficient width to accommodate a hospital bed.

The exterior walls of Wards VI-A and VI-B have been repainted.

Defective plumbing in Ward IV, the main kitchen, and the dining room area has been replaced.

The entrance to Ward I has been renovated and repaired by the removal of rotted woodwork.

The floor covering between Wards V and VI has been replaced with new linoleum.

A fire prevention sprinkler system has been installed in the storage area below Ward V-A and Ward III.





- d. Official Bed Capacity: The bed capacity has been reduced from 262 to 237 as of January 1, 1959. The chief purpose of this change was to establish recreation areas on Wards V-B and VI-B. This likewise reduced the number of patients per nursing unit, resulting in better nursing care.

Ward IV, with a capacity of thirty-three beds is still vacant.

### III. Unmet Needs or Plans for the Future:

- a. Establishment of an occupational therapy program. This program is essential to the care of tuberculosis patients, and patients with other chronic diseases. The present Arts and Crafts Program can only be made available to a small group. There are many other patients who need occupational therapy.
- b. This institution should have a standby generator for emergency use.

### IV. Personnel:

- a. The present staff of personnel can adequately care for a patient load of 205. If Ward IV is reopened for ambulatory patients, one additional position of inside porter will be needed.

If it is reopened for bed-rest patients, one additional position of inside porter will be required, plus three positions of kitchen helper.

- b. One full time, or two part time occupational therapists are needed to establish an adequate occupational therapy program.

Such personnel should have knowledge and training in the planning of a recreation program, in addition to occupational therapy qualifications.

### V. Equipment and Materials Necessary:

- a. Equipment and materials for the occupational therapy program.
- b. Furniture for recreation areas.
- c. Standby generator.



FISCAL YEAR	1953-54	1954-55	1955-56	1956-57	1957-58	1958-59
PATIENT DAYS	94,015	94,293	76,803	60,891	63,935	64,375
AVERAGE BED OCCUPANCY	259.94	258.43	209.50	166.80	175.18	176.79
SINGLE MEN'S REHABILITATION CENTER WORK LOAD						

Individual treatments and  
examinations

1,911

1,695

966

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\* Decrease due to inability to obtain replacement when Laboratory Technologist was ill, therefore no examinations were done.

FISCAL YEAR	1952-53	1953-54	1954-55	1955-56	1956-57	1957-58	1958-59
TOTAL ADMISSIONS	281	261	308	196	187	184	159
TOTAL DISCHARGES	287	274	309	253	213	174	166
IRREGULAR DISCHARGES							
RELEASES SIGNED	27	30	8	-	-	-	1
ABSENT WITHOUT LEAVE	41	56	68	56	26	39	30
DISCIPLINARY DISCHARGES	3	2	6	3	3	2	1
ROUTINE DISCHARGES	95	84	116	98	93	48	47
(O.P.D., P.M.D., L.H.H. or L.H.H. Inf.)							
TRANSFERS:							
(S.F.G.H. or OTHER HOSPITALS)	104	87	91	89	77	60	72
DEATHS	17	15	20	7	14	25	15
CENSUS	257	247	247	196	163	173	166



1956-57      1957-58      1958-59

LABORATORY TESTS

Sputum Concentrates Tubercle  
Urinalyses  
Blood Examinations  
Miscellaneous examinations

2,032      1,738      1,840  
6,849      7,177      5,208  
676      665      514  
607      2,874      2,824

X-RAY DEPARTMENT SERVICES

14" X 17"  
11" X 14"  
8" X 10"  
Dental Films

1,387      1,020      1,215  
291      157      126  
76      91      106  
26      19      8



SAN FRANCISCO GENERAL HOSPITAL

Fiscal Year 1958-59

1. Purpose and Scope

The Hospital is intended to care for all possible acute medical and surgical problems of the medically indigent residents of the City and County.

During the past fiscal year, it admitted and cared for 24,486 patients (increase 4%), giving 342,491 patient days of service (decrease 1.3%) at a gross average cost of \$25.02 per patient day, and a net cost to the taxpayer of just under \$20.00 per patient per day.

Of interest to your office is the fact that these two figures include the amounts appropriated in the budgets of the Controller and the Department of Public Works for bond interest and redemption and for deferred maintenance.

In addition to the in-patients noted above, the hospital cared for 75,859 out-patient visits (increase 9.7%) of which 35,841 were in Admission-Emergency (increase 10%), 14,439 were in Follow-up (increase 8.2%), 11,534 were in Pediatrics (increase 5.4%), 9,822 were in Pre- and Post-Natal (increase 16%) and 4,223 were in Psychiatry (increase 8.8%).

2. Program Activities

Our Bond-Deferred Maintenance Project Status Report #7, dated July 1, 1959 showed the following tabulations:

I	Construction Completed,	52 Projects Totaling	3,882,621.00
II	Construction Underway,	3 Projects Totaling	1,516,867.00
III	In Planning Stages	<u>10 Projects Totaling</u>	<u>3,727,750.00</u>
	Totals	65 Projects Totaling	<u>9,127,238.00</u>

Funds for these projects were obtained as follows:

Emergency Ordinance 1954	419,617.00
Budget 1954-55	225,300.00
Budget 1955-56	355,350.00
Budget 1956-57	301,854.00
Budget 1957-58	272,600.00
Budget 1958-59	415,035.00
Budget 1959-60	295,000.00
Budget 1960-61 (requested)	622,482.00
Budget 1961-62 (provisional)	690,000.00
Bond Funds	<u>5,530,000.00</u>

Total Funds	<u>9,127,238.00</u>
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It will be noted that all of the Bond Funds, except for approximately \$300,000.00 reserved for equipment, has been tentatively allocated as of this date. The modernization program can and will only be completed if the deferred maintenance budget (included in the budget of the Department of Public Works) is increased to the figures listed above, and continued for at least three years beyond the period listed.





During this fiscal year negotiations were completed with the University of California Medical School for a contractual agreement covering the laboratory, anesthesiology, and all medical services required for the patients. This contract assures continuity of service, in spite of the anticipated withdrawal of Stanford Medical School's coverage of one-half of the available beds.

In addition, it reduced to writing many of the informal "gentleman's agreements" which have existed between the University and the City and County ever since the association began in the mid nineteenth century.

Selfishly, this agreement guarantees that the patients of the City and County Hospital will receive the best possible medical care at the least possible expense to the taxpayer.

### 3. Unmet Needs

The budget for the last fiscal year was almost \$100,000.00 less than required. This was primarily due to two factors:

- a. The actual experience of previous years was disregarded in making new budget estimates; and
- b. Unpredictable increases in prices.

This institution is faced with the same condition for the fiscal year 1959-1960, because the final budget is approximately \$50,000.00 less than the amount needed for the immediately preceding fiscal year, and \$90,000.00 less than the amount requested.

This forces the administration into the untenable position of having to request additional supplemental funds long before any actual expenditures have been made.

Future plans, once the budgeting problem has been solved, involve closer correlation with the medical staff in determining the medical needs of the institution, and creation of a budget section in the Accounting Office to provide more adequate inventory, purchasing, and accounting controls.

### 4. Staff

With a total of 1,527 budgeted positions and an average of 938 patients, we have an average of 1.6 employees per patient. This is the lowest of any general hospital in the State, and is a source of daily "pseudo-emergencies" in order to provide nursing coverage for wards and patients where legitimate individual illnesses or other absences have stripped an already inadequate staff beyond the point where even reasonably good nursing care may be provided for our patients. We will again be requesting more positions for our nursing staff.

In addition, there is a demonstrable need for more middle echelon supervisory positions. Better training and closer supervision will effectively increase the productivity of individuals, and will reduce tardiness and absenteeism.

Positions in this category will also be included in our budget request for the coming fiscal year.



## 5. Equipment and Materials

Given an adequate budget as requested in #3 above, with sufficient controls to account for its proper use, and a reasonably adequate staff as requested in #4 above, there remains only the problem of equipment replacement.

At this point we have been satisfied with the policy of 10% replacement as laid down by your office. Difficulties have arisen because the Board of Supervisors have not always approved this policy, changing it to less than 4% two years ago.

If an agreement could be reached with the Board, our equipment should be kept in reasonably good condition if replacement was on a 10% basis each year.



## LAGUNA HONDA HOME

Total patient days for 1958-59 show a decline of 8,573 from the previous year from 596,805 to 588,232. The components of this total decrease are an increase in hospital patients' days of 31,266 and a decrease in ambulatory patient days of 39,839. Percentage of bed occupancy raised fractionally during 1958-59 to 98.16% for hospital beds and 97.66% for ambulatory beds.

The total number of admissions were identical for both 1957-58 and 1958-59 at 761. The number of discharges declined from a total of 845 for 1957-58 to 736 in 1958-59. The total number of patients and residents in the institution increased from 1602 on July 1, 1958 to 1627 on July 1, 1959. Total deaths declined from 329 during 1957-58 to 261 in 1958-59, a decrease of 68. The 1957-58 figure of deaths represented 20.53% of the average population, while the figure of 261 represented only 16.04% of the average population. This decline in the number of deaths is especially significant since the number of deaths has steadily declined for the past 15 years since 1943-44. During that year deaths were 531 or 28.96% of the average population. During this 15 year period, while deaths have declined, it is also noteworthy that the average age at death has risen from 69.6 years in 1943-44 to 76 years in 1958-59.

The decline in the number of deaths focuses attention as to the probable cause of this phenomena. While total patient care has steadily improved over the years, several specific phases contributing to this improvement are better medical and nursing care; use of new drugs and medicines; improved sanitation; housekeeping, laundry, etc.' improved food and diets and, in fact, all phases of institutional care. Furthermore, the educational, diversional, and recreational programs initiated by the School Department, Adult Education Division, and the activities of the Laguna Honda Home Volunteers are factors in improvement in total patient care.

### Bond Issue and Maintenance Projects

All projects for which funds were provided up to June 30, 1959 will be completed not later than December 1, 1959. Deferred maintenance projects for rehabilitation of "L" building will be advertised for bids on January 1, 1960 and completed by June 30, 1960. Funds for the latter project became available on July 1, 1959. The 270 additional hospital beds provided for by the 1954 Bond Issue will become available on January 1, 1960. Of these 270 available beds, 77 will be opened on January 1, 1960 and 77 more on March 1, 1960. Supplemental budget requests to provide personnel, supplies, etc. are now in process of review by the Mayor and the Board of Supervisors.

Total projects completed as of November 1, 1959 will have cost an aggregate of \$6,492,305. Upon completion of all these projects, bed capacities will be as follows:

Hospital	1214
Modified Hospital	260
Ambulatory	<u>543</u>
Total	2017

### Revenues and Collections

Collections for patients' care increased by \$318,326 from a total of \$1,006,032 during 1957-58 to \$1,324,358 in 1958-59. These collections represent 37½% of



the Laguna Honda Home operating budget, an increase of 5% over the previous year. Cost of collections (salaries) was less than \$40,000 for the year or about 3% of the collections. Collections from the Bureau of Delinquent Revenue are not included.

### Staffing

Several of the new positions requested in the 1958-59 budget and in the 1959-60 budget were approved. These were notably for nursing service and medical care. Additional nursing personnel provided an increase of nursing hours (per 24 hours of patient's care) from 1.45 to 1.55. In the budget of 1960-61 we will again request that nursing hours be raised to 1.75, the norm for similar hospitals in the State of California. Increases requested for housekeeping and laundry personnel in the 1959-60 budget as well as for previous years were practically nil. These essential services presumably lack the appeal that is present in a request for nursing and medical personnel and hence they do not fare so well, relatively speaking. We will again attempt to increase the staffing of these departments comparable to the norms for similar institutions.

### Recruitment of personnel

Recruitment of professional nurses has improved over a year ago. While there are seasonal factors in recruitment of Registered Nurses for the first time since before World War II, virtually all of the professional nursing positions are filled. On July 1, 1959 the assignment of medical interns by the University of California and Stanford Medical Schools to Laguna Honda Home was terminated. This date marked the end of the program dating from about 1926 or earlier. A supplemental budget was submitted and approved for the employment of accredited doctors to replace the services of the teaching faculty supplied by the medical schools for the teaching of interns. While it was feared that the withdrawal of interns and their teachers would lower the level of patient care, there are indications during the short time that the new program has been in effect that medical care will be sustained at a high level. Virtually all the new physicians recruited are either members of National Boards for their respective specialties or are eligible for such membership by virtue of academic training and experience. A supplemental budget was submitted in the approximate sum of \$20,000 for payment for professional consultant services formerly provided by the teaching faculties of the respective medical schools. This request recommended an hourly rate of \$25.00. This suggested figure was confirmed through the County Medical Society and is in effect at Veterans and Government Hospitals. The request of \$20,000, however, was reduced to \$6,000 for the year, which provides us with only about one third of the consultation time thought necessary. Additional experience is needed before the amount of a supplemental budget request for this purpose can be estimated.

There are two other Civil Service classifications for which recruitment is still inadequate. These are Physical Therapists and Clinical Laboratory Technologists. The national shortage of Physical Therapists has made competition keen for competent and trained personnel and the few available are presumably attracted to better paid positions. The shortage of therapists has and will continue to retard the program of patients' rehabilitation at Laguna Honda Home. Clinical Laboratory Technologists, still in short supply, usually lack training for work in Bacteriology. This is a great need at Laguna Honda Home. We recommend that the Civil Service Commission use adequate and extraordinary measures in recruiting personnel for these classes.





## PERSONNEL DIVISION

During the fiscal year 1958-59 the Personnel Office issued 571 permanent requisitions, 713 temporary requisitions, and 1632 extensions of temporary employment. This compares with 637 permanent requisitions, 768 temporary requisitions, and 1241 extensions of temporary employment for the fiscal year 1957-58.

Certain employments in the institutions of the Department continue to show an excessive turnover rate. Analysis of separations in permanent positions of Registered Nurse, Orderly, Porter, and Kitchen Helper reveals the following:

		<u>1958-59</u>	<u>1957-58</u>
Registered Nurse:	S.F.G. Hospital	30.5%	38.6%
	Laguna Honda Home	18.5%	20%
	Hassler Health Home	28.5%	14%
Orderly:	S.F.G. Hospital	22%	25%
	Laguna Honda Home	25.5%	27%
	Hassler Health Home	34.5%	17%
Porter:	S.F.G. Hospital	13%	25%
	Laguna Honda Home	35%	28%
	Hassler Health Home	33%	56%
Kitchen Helper:	S.F.G. Hospital	10.5%	26%
	Laguna Honda Home	18.5%	34%
	Hassler Health Home	---	22%

It is relevant to point out that the turnover at San Francisco General Hospital and Laguna Honda Home decreased slightly in these four categories; whereas the turnover at Hassler Health Home increased slightly for Registered Nurses and Orderlies and decreased for Porters and Kitchen Helpers.

On July 1, 1958, Mr. Chester MacPhee assumed the office of Chief Administrative Officer, and the Personnel Officer of the Health Department was assigned to work as part of a survey team directly under his supervision for several months. During this time a complete reevaluation of the adequacy of the nursing personnel was made. As a result of this survey, Mr. MacPhee released all positions budgeted for patient care except nine positions of registered nurse. These were withheld because of the low patient load during the summer months, but all but two of these positions were eventually released. Upon taking office later in the fiscal year, Mr. Sherman P. Duckel released the final two requisitions.

On or about January 1, 1959, 38 chronic type patients were transferred from San Francisco General Hospital to Laguna Honda Home, and the positions required for their care were also transferred to Laguna Honda Home.

A time study was made of all Kitchen Helper personnel assigned to the ward service at San Francisco General Hospital. The study was made with the assistance of Mr. James Kirby, who was temporarily reassigned as Senior Clerk in the Death Registration Division. This study showed that the best use was not being obtained from the services of Kitchen Helpers, due to various factors, which included (1) improper spacing of meals, and (2) questionable assignment of personnel without regard to the work load in the wards. As a result of this preliminary investigation, it was decided to enter into a contractual agreement



with a private contractor to survey the entire food service setup at San Francisco General Hospital. A contract was later entered into which also included Laguna Honda Home. To date, this study has not been completed.

In several previous reports we have mentioned the scarcity of Blood Bank Technicians. This has been due, in part, to the fact that a separate classification existed for these positions and the compensation was lower than the prevailing rate for Clinical Laboratory Technologists. This is primarily a classification problem. In order to correct this situation, the Civil Service Commission will be asked to eliminate the Assistant Clinical Technicians Blood Bank and Clinical Technicians Blood Bank, and to incorporate the duties of these positions into the general classification of L55 Clinical Laboratory Technologist. In this manner, Technicians may be rotated in and out of the Blood Bank while continuing to perform generalized duties related to the Clinical Laboratory at San Francisco General Hospital.

We continue to experience difficulty in recruiting and retaining Psychiatric Social Service Workers, five of such positions now being vacant in the Central Office and two in San Francisco General Hospital. During the year we placed an ad in a national periodical for Psychiatric Social Worker without tangible results.

At this writing there is one position of Physical Therapist and one position of Senior Physical Therapist vacant at Laguna Honda Home. Several times we have engaged in a recruitment program to attract qualified technicians, and during the fiscal year we sent out examination announcements to at least 200 Physical Therapists who had been registered with the State Board of Medical Examiners during the calendar years 1958 and 1959. Despite these efforts, the jobs remain unfilled.

Part of this problem, in relation to Physical Therapists, had its origin in the wording of the State law which would not permit a qualified therapist coming to California from another state to practice in this profession until he had passed the State examination. At our request, and with the approval and cooperation of the legislative representative at Sacramento, the Business and Professions Code was amended to eliminate this restricting section. It is hoped that better results can be obtained in recruitment in the future.

During the year the orientation program of Central Office continued. A total of 52 new employees benefited from this program during the year.

Although much thought had been previously given to the training of supervisors, it was not until the past fiscal year that positive action was taken. Two programs resulted from this activity: (1) A series of films, obtained through the McGraw-Hill Publishing Company on the problems of supervision were shown to Public Health Nurses and Staff Supervisors throughout the department. The Personnel Officer led the discussion and pointed out the areas of supervision which were being exemplified in the films. These were well received by those who viewed them, but very few supervisors from San Francisco General Hospital attended these film showings. A program of this type should not be optional, and all supervisory personnel should be required to attend these showings. (2) An agreement was reached with the San Francisco State College to conduct a series of seminars for supervising public health nurses. Dr. Phillip O. Foss conducted the nine seminars during the period April 9 through June 4, 1959. The program was well received and it is recommended that this relationship between



the Health Department and the State College be continued to the end that all supervisory personnel receive this type of instruction.

During the fiscal year, an advertisement for Registered Nurses appeared in issues of the American Journal of Nursing magazine. During the fiscal year 1958-59 letters were received from 88 registered nurses who had read these advertisements. It is estimated that at least 50% of these inquiries resulted in hiring young nurses from other states and on that basis the investment in the advertisement paid off many times over. This type of recruitment should be continued as the hospitals in California have exhausted the supply of nurses in this locality.

The Personnel Officer, who served in this capacity since 1942, transferred out of the Health Department at the close of business July 2, 1959. The position will be filled permanently shortly.



## ACCOUNTING DIVISION

During the course of the fiscal year 1958-1959 shortages appeared in many of the appropriations of the Department of Public Health. Reasons for these shortages can be divided into several categories. They can generally be enumerated as follows:

1. Increases in contracts as awarded for specific services by the Purchaser of Supplies.
2. Price increases on items budgeted a year in advance.
3. Increased services because of public demands.
4. Additional requirements to comply with provisions in State Contracts for reimbursement.
5. The additional program for Community Mental Health Services.

In the Central Office, Revenues Estimated were exceeded by the Revenues Received by \$135,008.00. The main increase was an offset of unrealized revenue in Crippled Children Services for the fiscal year 1957-1958. All other increases and decreases were minor.

Following is the summary of financial operations of the Department of Public Health.





DEPARTMENT OF PUBLIC HEALTH - CENTRAL OFFICE BUREAUS - OTHER THAN PERSONAL SERVICE ACCOUNTS

Account No.	1958-59 Budget Allowance	Adjustments	1958-59 Adjusted Allowance	Expended & Encumbered	Balance
<u>Accounting</u>					
8.511.200.000	75		75	35	40
8.314.225.511	600		600	599	1
8.511.300.000	313	31(a)	344	339	5
8.311.400.511	189	(31)	158	158	-
<u>Administration</u>					
8.513.200.000	22828	5090(a)	27918	25431	2487
8.513.200.098		300(c)	300	300	
8.513.203.000		80(c)	80		80
8.312.216.513	924	294(a)	1218	1218	-
8.313.224.513	1200		1200	1287	(87)a
8.314.225.513	525		525	525	-
8.715.231.513	6650	310(a)	6960	6864	96
8.311.232.513	10000	(252)	9748	16195	(6447)a
8.311.237.513	274	304(a)	578	578	-
8.513.267.000	37000	35176(ac)	72176	36595	35581
8.513.300.000	2070	500(a)	2570	2492	78
8.311.321.513	555	51(a)	606	606	-
8.311.370.513	67	11(a)	78	78	-
8.311.375.513	350	(40)	310	279	31
8.311.400.513	4549	2577(ac)	7126	6655	471
8.513.800.000	18080	3500(a)	21580	21512	68
<u>Adult Guidance Center</u>					
8.515.200.000	985	230(b)	1215	1090	125
8.515.200.098.3		1850(b)	1850	691	1159
8.515.200.098.3.1		4000(b)	4000	4000	-
8.515.200.098.3.2		4000(b)	4000	4000	-
8.515.200.098.3.3		1300(b)	1300	1300	-
8.515.203.000	700		700	689	11
8.515.300.000	21656	3070(a)	24726	23634	1092
8.311.400.515	350		350	299	51
8.515.800.000	35		35	35	-
<u>Bacteriological Laboratory</u>					
8.517.200.000	145		145	8	137
8.517.300.000	4185	3500(a)	7685	7523	162
8.311.340.517	130		130	62	68
8.311.400.517	180		180	170	10
<u>Chemical Laboratory</u>					
8.519.200.000	390		390	168	222
8.519.300.000	601		601	599	2
8.311.400.519	277		277	252	25
<u>Maternal &amp; Child Health</u>					
8.521.200.000	375	431(a)	806	526	280
8.521.203.000	200	120(a)	320	316	4
8.521.267.000	387945		387945	387945	-
8.521.300.000	9252	367I(a)	12923	12837	86
8.521.372.000	1150	35(a)	1185	1182	3



DEPARTMENT OF PUBLIC HEALTH - CENTRAL OFFICE BUREAUS - OTHER THAN PERSONAL SERVICE ACCOUNTS

Account No.	1958-59 Budget Allowance	Adjustments	1958-59 Adjusted Allowance	Expended & Encumbered	Balance
<u>Maternal &amp; Child Health-cont'd.</u>					
8.311.400.521	1276	(266)	1010	983	27
<u>Communicable Diseases</u>					
8.525.200.000	1364	(50)	1314	1272	42
8.525.203.000	500		500	375	125
8.312.216.525	175		175	52	123
8.525.300.000	4144	106(a)	4250	4250	-
8.311.321.525	130	21(a)	151	151	-
8.311.400.525	177	(45)(a)	132	132	-
<u>Dairy and Milk Inspection</u>					
8.527.200.000	5249	(300)	4949	4365	584
8.312.216.527	3500	800(a)	4300	3816	484
8.527.300.000	965	300(a)	1265	1211	54
8.311.321.527	4800		4800	4558	242
8.311.400.527	515		515	465	50
<u>Dental Bureau</u>					
8.529.200.000	285		285	283	2
8.529.203.000	320		320	318	2
8.529.300.000	1397	200(a)	1597	1573	24
8.311.340.529	146		146	129	17
8.311.400.529	364		364	341	23
<u>Food &amp; Sanitary Inspection</u>					
8.531.200.000	6508	(156)	6352	6352	-
8.531.203.000	5000		5000	5000	-
8.312.216.531	1300		1300	868	432
8.311.240.531		156(a)	156	156	-
8.531.300.000	1324	312(a)	1636	1636	-
8.311.321.531	1400		1400	1149	251
8.311.400.531	1823	463(a)	2286	2115	171
<u>Mental Hygiene</u>					
8.533.200.000	200	180(c)	380	136	244
8.533.300.000	375	34(c)	409	409	-
8.311.400.533	293	520(c)	813	743	70
<u>Public Health Education</u>					
8.537.200.000	205	13(a)	218	218	-
8.537.300.000	2782	(13)	2769	2708	61
<u>Public Health Nursing</u>					
8.539.200.000	26427	(23200)	3227	3023	204
8.539.200.001		23200	23200	23200	-
8.539.203.000	8700		8700	8619	81
8.312.216.539	750		750	748	2
8.715.231.539	1350		1350	1242	108
8.311.237.539	703	102(a)	805	805	-
8.539.300.000	5880	2900(a)	8780	8741	39
8.311.321.539	400	37(a)	437	437	-



DEPARTMENT OF PUBLIC HEALTH - CENTRAL OFFICE BUREAUS - OTHER THAN PERSONAL SERVICE ACCOUNTS

Account No.	1958-59 Budget Allowance	Adjustments	1958-59 Adjusted Allowance	Expended & Encumbered	Balance
<u>Public Health Nursing - cont'd</u>					
8.311.340.539	400		400	238	162
8.539.350.000	12700	(9100)	3600	3589	11
8.311.375.539	50		50	28	22
8.311.400.539	6606	1849 (a)	8455	7304	1151
8.245.880.539	8880		8880	8880	-
<u>Statistics</u>					
8.541.200.000	1756	90 (a)	1846	1786	60
8.541.225.541	2200		2200	2200	-
8.541.300.000	4702		4702	4653	49
8.311.400.541	1501	(90)	1411	1411	-
<u>Tuberculosis Bureau</u>					
8.543.200.000	970		970	940	30
8.543.203.000	325		325	299	26
8.543.300.000	630	350 (a)	980	962	18
8.543.372.000	7000	2187 (a)	9187	8625	562
8.311.400.543	382		382	319	63
<u>V. D. Control</u>					
8.545.200.000	642	10 (a)	652	652	-
8.545.203.000	250		250	187	63
8.715.231.545	1230		1230	1063	167
8.311.237.545	148	22 (a)	170	170	-
8.311.240.545	156		156	156	-
8.311.256.545	150	30 (a)	180	180	-
8.545.300.000	4171	(185)	3986	3447	539
8.311.340.545	228	(180)	48	26	22
8.311.375.545	120		120	92	28
8.311.400.545	1260	325 (a)	1585	1557	28
8.545.800.000	19		19	19	-
8.245.880.545	2880		2880	2880	-
Total Central Office	684888	70730	755618	713314	42304

(a) 1958-59 Budget allowance proved to be inadequate for normal programs.

(b) Funds appropriated for State of California.

(c) Funds appropriated for Community Health Services.



DEPARTMENT OF PUBLIC HEALTH - COMPARISON OF BUDGET ESTIMATE WITH  
ACTUAL REVENUES

FISCAL YEAR 1958-1959

CENTRAL OFFICE

Revenue Acct. No.	Source	Budget Estimate	Actual Receipts*
3103	Public Eating Places	56000	57426
4501	Penalties	200	460
7502	Milk Inspection	130000	159574
7526	Food Vehicle Permits	400	378
7527	Poultry Dealers	1000	1460
7528	Salvaged Goods	50	-
7530	Public Welfare - Reimbursements	5000	1757
7543	Fumigation Inspection	40	212
7544A	Laundry Renewals	2000	2808
7544B	Laundry Opening	180	1430
7549	Refuse Collectors	800	841
7562	Massage Parlors	200	260
7581	Birth Certificates	21500	21426
7582	Death Certificates	30000	35201
7583	Removal Permits	9400	10034
7590	Burial Refunds	2500	8315
7590	Travel Certificates	7000	8878
7625	Adult Guidance Center	3400	8255
7660	Crippled Children's Services (Parents)	15000	23826
7669	Sheriff's Transportation	7000	5599
9806	Miscellaneous Refunds	700	565
6538	Salary Refund (Federal)	40000	41434
6540	Special Public Health Fund	175000	178862
6760	Crippled Children's Services (State)	200000	273621
6785	Alcoholic Rehabilitation	65000	62246
6786	Mental Health Services	357325	359835
		<u>1129695</u>	<u>1264703</u>

\*Includes Accounts Receivable as well as fees received.





DEPARTMENT OF PUBLIC HEALTH - EMERGENCY HOSPITAL SERVICE - OTHER THAN  
PERSONAL SERVICE  
ACCOUNTS

Account No.	1958-1959 Budget Allowance	Adjustments	1958-1959 Adjusted Allowance	Expended & Encumbered	Balance
8.551.200.000	420	200(a)	620	518	102
8.551.203.000	100		100	99	1
8.312.216.551	8700	3350(a)	12050	12025	25
8.314.225.551	750		750	750	-
8.715.231.551	3550		3550	3125	425
8.311.232.551	2502		2502	2601	(99)a)
8.555.236.551	4485		4485	4474	11
8.311.237.551	808	1(a)	809	809	-
8.311.240.551	96		96	96	-
8.551.300.000	8785	1315(a)	10100	10088	12
8.557.300.551	2600		2600	2585	15
8.311.321.551	5200		5200	4612	588
8.311.340.551	2000		2000	1701	299
8.551.350.000	1100		1100	1020	80
8.311.351.551	100		100	87	13
8.311.370.551	48		48	48	-
8.311.375.551	25		25	22	3
8.311.400.551	16540	(200)	16340	15050	1290
Total	57809	4666	62475	59710	2765

(a) 1958-1959 Budget Allowance proved to be inadequate for normal programs.



DEPARTMENT OF PUBLIC HEALTH - HASSLER HEALTH HOME - OTHER THAN PERSONAL  
SERVICE ACCOUNTS

Account No.	1958-1959 Budget Allowance	Adjustments	1958-1959 Adjusted Allowance	Expended & Encumbered	Balance
8.553.200.000	11225	(2890)(a)	8335	8071	264
8.553.200.000.01		3500	3500	3500	-
8.553.203.000	120	5(a)	125	124	1
8.312.216.553	1400		1400	1144	256
8.715.231.553	21000	5450(a)	26450	23537	2913
8.311.232.553	2600		2600	2883	(283)a)
8.311.256.553	576	132(a)	708	696	12
8.553.300.000	23535	(475)	23060	21596	1464
8.311.321.553	2000	(132)	1868	1677	191
8.311.340.553	2000	2000(a)	4000	3276	724
8.553.350.000	59935		59935	56904	3031
8.311.351.553	7500	(1767)	5733	5368	365
8.555.355.553	14750	3440	18190	18190	-
8.553.372.000	1285	(255)	1030	935	95
8.311.375.553	375		375	272	103
8.311.400.553	6500	570(a)	7070	7034	36
8.553.800.00	1622	65(a)	1687	1687	-
Total	156423	9643	166066	156894	9172

(a) 1958-1959 Budget Allowance proved to be inadequate for normal programs.



DEPARTMENT OF PUBLIC HEALTH - COMPARISON OF BUDGET ESTIMATE WITH  
ACTUAL REVENUES

FISCAL YEAR 1958-1959

HASSLER HEALTH HOME

Revenue Acct. No.	Source	Budget Estimate	Actual Receipts*
6539	Tuberculosis Subsidy	132500	176705
6835	Patients Unclaimed Funds	100	100
7632	Meals Miscellaneous	300	611
9801	Telephone Refund	40	40
	Total	<u>132940</u>	<u>177456</u>

\*Includes accounts receivable as well as fee received.















